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# Review of Maternity Homes in Ontario

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Bonnie Hoppe
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# INTRODUCTION

This paper provides a profile of a sample of residents who were in a maternity home in 1979 and 1981 comparing them, where possible, to a previously studied group of maternity home residents and to unwed pregnant women in the general population. This profile illustrates in a preliminary way, the extent to which maternity home residents are vulnerable or at risk. This paper also describes the programs offered by the homes and comments in a general way on their appropriateness.

The purpose of this document is to identify and discuss some of the issues and concerns faced by maternity homes. Some suggestions for future courses of action are highlighted. Because of the limited scope of the survey, this paper does not by itself provide a sufficient basis with which to make policy decisions though it should be useful for program planning and review.

This paper is to be distributed to maternity home staff and board members, Ministry staff, children's aid societies, other social service agencies, other relevant Ministries and others (e.g., social work students, researchers) with a particular interest in maternity homes and unwed pregnancy.

Any comments or reactions to this paper are invited. Please submit them in writing to:

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Copies of the questionnaire, data collection form and tables of data can be obtained from Bonnie Hoppe.

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# I BACKGROUND

Over the years as society's attitudes toward illegitimacy and unmarried parenthood have changed, so have services for that population. Consequently, any review of the future role of maternity homes needs to have some awareness of prior developments and the major forces within the present and foreseeable future.

Leontine Young, in her classic book on unmarried mothers in the United States, provides an overview of the early development of maternity home services. She notes that maternity homes, which were referred to as shelters, began to be established during the latter half of the nineteenth century, chiefly by private charitable or religious organizations. They grew out of a need to provide a safe haven for unmarried pregnant women and unmarried mothers with their babies.(1) Religious motives also underlied the provision of maternity home services in the beginning. An example of this is found in the Constitution of the Sisters of Misericorde, a religious group formed in 1845 to come to the rescue of single pregnant women. Their special vocation was to purify and sanctify the souls, who after having the misfortune to go astray, sought in religion a safe asylum in which they repaired their fault and at the same time hid from reproach.(2) Today this religious order speaks of rehabilitation instead of purification.

The homes most frequently pressured the mother to keep her baby and to remain there for fixed periods of months after the baby was born. While this was seen at the time as a form of ongoing penance and a necessary step in the unmarried mother's redemption(3), it must also be remembered that her other options were to abandon the child or relinquish the child to an orphanage, that there was a lack of financial resources and supports from family, friends and the government and that there were limited employment opportunities other than domestic work for these women to earn money.

In Ontario, there were similar concerns regarding illegitimacy and prostitution because infants were being deserted, farmed out to nursing homes or adopted for lump sums of money. A series of legislative acts and amendments were passed which represented a progression of attempts to improve the situation. In 1887 The Protection of Infants Act was passed requiring private nursing homes to be licensed and inspected by municipalities. The Act was repealed in 1897 and was replaced by The Maternity Boarding Houses Act, 1912.

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[1] Leontine Young, Out of Wedlock (Toronto: McGraw-Hill Book Co. Inc., 1954), p. 218.

[2] Ev. de Philip Georges The Beginnings of the Community of the Sisters of Misericorde (Montreal, 1921), pp. 12.

[3] Young, op.cit., pp. 218-220.

The Maternity Boarding Houses Act provided for the registration of maternity and infant boarding homes by the medical officer of health. All births in maternity homes had to be attended by a qualified doctor and the home was required to see that all births were registered.(4) This provision ensured that children would no longer be left on the streets to be cared for and that the adoption of children for large amounts of money would be stopped.(5) These changes together with the activities of children's aid societies ameliorated the situation that had been identified prior to 1887 but had not been resolved by previous legislative efforts.

With the passage of The Children of Unmarried Parents Act in 1921 further efforts were made to improve the welfare of unmarried mothers and their children. A statutory guardian was provided for the mother and her child. The child, if no one would care for it, could be taken into the custody of a children's aid society, thus being protected against abandonment or neglect. In addition, affiliation orders could be made between the provincial guardian and the putative father (i.e. the father of the baby) in favour of the mother and child. It should be noted that The Mothers' Allowances Act, passed one year earlier, excluded unmarried mothers from financial assistance.(6)

By 1925, more than half of the present maternity homes had been established. They reinforced the social values and societal practices of that time by providing a residence where unmarried pregnant women could prepare for the birth of their children in supportive, experienced and medically supervised surroundings. The homes also tended to be primary adoption facilities for the community at large, as the great majority of women using maternity homes did not keep their babies.(7)

The changes following 1925 were more gradual. A few significant events are worth noting. In 1927, The Charitable Institutions Act was passed in an effort to consolidate various pieces of legislation respecting Charity Aid, the regulation of Public Aid to Charitable Institutions, the inspection of Prisons and Public Charities and Hospitals and Charitable Institutions. Maternity homes were included in this legislative change as one type of charitable organization. The homes remained funded under this legislation until they were transferred to The Children's Institutions Act in 1980.

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[4] Ontario, Department of Public Welfare, An Historical Review of Ontario Legislation on Child Welfare, by C. Owen Spettigue (n.d.), pp. 27-28.

[5] Ontario, Office of the Superintendent of Neglected and Dependent Children of Ontario, Neglected and Dependent Children of Ontario - 1898, by J.J. Kelso (1899), p. 16.

[6] Ontario, Department of Public Welfare, An Historical Review of Ontario Legislation on Child Welfare, pp. 39-41.

[7] Ontario, Ministry of Community and Social Services, Operational Review: Children's and Youth Institutions, Final Report, by Peter Turner (May 1979), p. 72.

Many of the charitable institutions including maternity homes operated on an uncertain and unstable financial base. It became clear in the depression years (i.e., the 1930s) that service could not be provided using funds solely from voluntary sources. Consequently, the charitable organizations began obtaining financial support from public sources as well. By the mid 1950s, the institutions were subsidized eight dollars per month, per resident in the institution on the last day of each month. And by the late 1960s, when The Charitable Institutions Act was amended, the subsidy was raised to eight dollars per day per resident. The amendment to the Act also allowed for an increase in operating grants upwards to 80% of the budget. Despite these increases, it was noted at the time that the staff salaries in the charitable institutions were insufficient to compete with salaries in other children's services.

Because of the funding inequities and other inconsistencies and conflicts (e.g. standards and supervision, eligibility and admission criteria) among the various provincial residential services, the Ministry of Community and Social Services established a committee in 1975 to develop an overview and make some recommendations regarding these services. The document prepared by this committee, known as the Anderson Report, noted some major problems and issues with children's and youth facilities, in general, and with maternity homes, in particular (e.g. a younger and more disturbed clientele, an increase in residents keeping their babies and major financial difficulties).

Following the release of that document, the Ministry began conducting a series of operational reviews to help improve the effectiveness of children's services and to provide a comprehensive analysis and evaluation of goals, legislation, funding and operations. An operational review of all children's and youths institutions, which included maternity homes, was conducted during 1978 and 1979. That review addressed a number of issues respecting maternity homes, reiterating those raised earlier in the Anderson Report. The review also outlined a number of recommendations which directly affected the role and functions of maternity homes. For example, it was recommended that: the homes reduce residential capacity in response to the decline in utilization; the homes develop non-residential child abuse prevention and family crisis intervention programs; and the homes develop programs for unwed mothers and their babies where young mothers could be cared for and trained in mothercraft at the same time.

To respond to these concerns and recommendations, the Ministry transferred funding arrangements for maternity homes from The Charitable Institutions Act to The Children's Institutions Act. This removed the previous ceiling on per diem cost sharing and the fixed cost sharing formula. It also set up a form of joint planning through the device of annual program and financial planning cycles.

Many of the changes in the maternity home program over time relate to the changes in societal attitudes and legislation toward unmarried pregnant women and unmarried mothers. This is particularly true in regard to the changes which occurred in the 1960s and early 1970s. For example, the attitudes toward sexuality and sexual behaviour changed during this time. Pre-marital intercourse among teenagers became much more of an accepted pattern of behaviour. In fact, recent research in the United States has shown that about half of today's youths are sexually active by the time they reach age 18 and about 75 percent engage in sexual activity by age 21.(8) These attitudes and practices were affected by the feminist movement which has pushed toward equality in sexual behaviour and has reduced the double standard of sexual behaviour.(9) The change in the laws on contraception and the availability of contraceptives, especially the birth control pill, enabled women to prevent pregnancies. The liberalization of the abortion laws allowed them greater freedom to terminate unwanted pregnancies.

During this time society's attitudes changed towards a greater acceptance of out-of-wedlock pregnancies. As a result, it became more acceptable for unmarried pregnant women to remain in their home community. The schools had made efforts to accommodate such students. For example, around 1970, a couple of the Boards of Education in Metropolitan Toronto amended their policy of empowering the principal to expel pregnant students in order to permit pregnant students to remain in the classroom if they so desired. Despite this, many pregnant adolescents did not remain in the school but chose alternatives such as home instruction if available, enrollment in a maternity home school on a non-residential basis or more often departure from school. Thus, the provision of continuing education became a major component of the maternity home program.

It also became more possible and socially acceptable for unmarried mothers to keep their babies rather than release them for adoption. This change in attitude was first apparent in the late 1950s when the Province of Ontario passed legislation (The Mothers' and Dependent Children's Allowances Act, 1957) which enabled a mother of a dependent child born out of wedlock to receive an allowance. This allowance program was administered by the Municipalities under The General Welfare Assistance Act (1958). Subsequently, when The Family Benefits Assistance Act (1967) was passed, it also included unmarried mothers to be eligible for income maintenance payments. For the majority of unmarried mothers this has now become the major or only source of financial support.(10) In addition, in 1971 maternity leave and the guarantee of their jobs after the birth of the child were provided under the Unemployment Insurance Program. This income from employment made it possible for others to raise their children independently. And, the changes in attitude were also reflected in The Ontario Family Law Reform Act (March 1978). Among other things, it provided equal status for children for all purposes of the law of Ontario, regardless of whether they were born within or outside of marriage.

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[8] Catherine S. Chilman, "Teenage Pregnancy: A Research Review," Social Work (November 1979) :492.

[9] Ibid.

[10] Caseload data on the Family Benefits Assistance program for the period from 1969 to 1979 showed that a growing number of unwed mothers were dependent on this form of financial support. In 1969, 4,122 unmarried mothers were in receipt of FBA. By 1979, the number has increased to 15,629. Source: Doris E. Guyatt, "Children Raising Children", presentation at the conference of the Ontario Association of Children's Aid Societies and the Child Welfare League of America, Toronto, April 24, 1981.

As a result of these and related factors (e.g. a change in the clientele), maternity homes in the 1960s and 1970s were faced with a marked decline in utilization. The average rate of occupancy based on 329 beds dropped to 80% in 1970 and further decreased to 62% in 1971.(11) From 1972 to 1975 the rate oscillated between 67% and 61%.

Because of this low occupancy level, in 1976 one home closed. A few homes (four) modified their original mandate by diversifying their programs to include a residential program for non-pregnant girls (e.g. troubled or delinquent adolescents). A number of homes (five) expanded their programs for married pregnant women and/or for women (usually former residents) with their newborn babies. Most homes (eight) developed non-residential programs for pregnant women and for new mothers choosing to reside at home but wishing to participate in the school and pre-natal programs. Several of the homes also reduced the number of their beds. By 1976 the provincial bed capacity totalled 262 beds, a reduction from 329 beds in 1972. This number further dropped to 197 in 1979-1980.(12)

The decrease in demand for maternity home service also resulted in a decrease in the total maternity home resident days care. In 1972, the days of care totalled 81,662. By 1979-1980 the total only reached 59,628 - a reduction by 27%. There was, however, a marginal increase of 176 days in 1980-1981. Despite the general pattern of fewer days care, the lower bed capacity caused the occupancy rate to increase to 85% in 1979-1980 from 67% in 1972. Thus, the bed closures removed the homes' surplus capacity and increased the utilization rate of the remaining beds. The following table illustrates the pattern of utilization for the period from 1972 to 1980-1981.

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[11] Doris E. Guyatt, "Adolescent Pregnancy: A Study of Pregnant Teenagers in a Suburban Community in Ontario" (Ph.D. dissertation, University of Toronto), 1976 p. 10.

[12] Recording of statistical data for the Ministry changed from the calendar year to the fiscal year as of 1979.

## Maternity Homes: Utilization Pattern

## 1972 to 1980 - 1981

| | Number of Homes | Bed Capacity | Resident Days Care | Occupancy Rate (%) |
|---|---|---|---|---|
| 1972 | 14 | 329 | 81,662 | 66.9 |
| 1973 | 14 | 329 | 76,154 | 61.3 |
| 1974 | 14 | 329 | 70,733 | 62.2 |
| 1975 | 14 | 329 | 71,236 | 65.8 |
| 1976 | 13 | 262 | 68,089 | 64.7 |
| 1977 | 13 | 262 | 69,379 | 66.9 |
| 1978-1979 | 13 | 223 | 64,286 | 79.5 |
| 1979-1980 | 13 | 197 | 59,628 | 85.1 |
| 1980-1981 | 13 | 197 | 59,804 | 84.8 |

NOTE: Statistics were not available for one home from 1975 onwards. Therefore, data on bed capacity, resident days care and occupancy rate for 1975 is based on 13 homes and from 1976 to 1980-1981 it is based on 12 homes. In addition, bed capacity is an approximation for some homes.

Maternity homes were established to respond to the needs of unmarried pregnant women and unmarried mothers with their babies. The increased concerns about teenage pregnancy and teenage mother-led families influenced maternity homes to modify and expand their statements of purpose. The following list outlines the common set of objectives of maternity homes in Ontario at present:

- provision of accommodation and emotional support to protect the unmarried pregnant women from social stigma by the community and rejection by the family;

- preparation of women for the birth of their babies:
  - prevention of maternity-related illnesses which pose health risks to the pregnant woman and the baby;

- facilitating informed decision-making:
  - preparation for single parenthood,
  - prevention of child abuse and neglect,
  - provision of knowledge of the adoption process;

- enhancement of individual and family functioning:
  - identification and amelioration of problems unrelated to the pregnancy (eg. family conflict, drug and alcohol abuse),
  - assistance in coping with separation from the baby,
  - prevention of further unplanned pregnancies,
  - the fostering of individual self-esteem and assistance in setting individual goals for the future,
  - improvement of relationships with others,
  - promotion of life skills (eg. homemaking) for independent living,
  - provision of educational and vocational counselling.

## II PURPOSE OF THE REVIEW

The Operational Review: Children's and Youth Institutions (May 1979) recommended that the existing level of service provided by the maternity homes needed to be appraised before the Ministry developed any comprehensive package of maternity-related programs. That review supported the continued existence of maternity homes, stating that they were in many ways the most logical and experienced facilities to develop programs related to prevention. Such programs could be provided on a non-residential as well as a residential basis.

Further support for reviewing maternity homes comes from the changing and possibly opposing views regarding unmarried mothers and their parenting capacity. The Lightman and Schlesinger study of maternity home residents in Ontario (1979) described the typical pregnant woman planning to keep her baby as having less education, residing in public housing, an apartment or some other situation but not with parents, having lived in a one-parent family unit where the parents were separated or divorced, having a greater probability of a serious illness or handicap and more likely having undergone psychiatric treatment. They concluded that many of the unwed mothers who intended to keep their infants appeared to be the least likely to become adequate mothers on the basis of personality and family life experiences (Lightman(13)). This would seem to suggest cause for considerable concern. However, it is important to keep in mind that their findings are based on the mothers' initial stated intentions and not on their final decisions.

Other researchers who have studied unwed teenage women who actually kept their babies have arrived at a contrary conclusion. Their findings suggest that unmarried (teenage) mothers generally manage quite well and care adequately for their children (Youtz(14)), MacDonnell(15)). However, it is unclear from these studies whether or not the mothers had been admitted to a maternity home during their pregnancy. Consequently, the difference in findings between these studies and the Lightman and Schlesinger study may be based on different populations as well as on differences between the characteristics of unmarried mothers who stated an intention to keep as opposed to those who actually kept their children.

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[13] Ernie S. Lightman, "Intake at Ontario's Maternity Homes: Those Planning to Keep the Child and Those Intending to Give for Adoption," Toronto, February, 1979. (Mimeographed.), pp. 14-15.

[14] Ontario, Ministry of Community and Social Services, Policy Analysis Secretariat, Unmarried Teenagers on Provincial Benefits - Final Report, by Robert Youtz (June 1975), p. 30.

[15] Susan MacDonnell, Vulnerable Mothers, Vulnerable Children: A Follow-Up Study of the Unmarried Mother Who Keeps Her Child (Halifax: Policy, Planning and Research Division, Nova Scotia Department of Social Services, 1981), p. 286.

Despite these more optimistic reports, there still is concern about the unwed mothers, especially adolescents, who keep their children. This concern is related to a variety of risk factors that are apparent in teenagers even before they become pregnant and/or as the pregnancy advances, immediately following the birth and in the early years of the child's life. These factors are as follows:(16)

- the incomplete biological, emotional and intellectual development of adolescents;
- the prevalence of smoking, drugs and alcohol during adolescence adversely affecting the pregnant woman and the fetus (e.g. low birth-weight, neurological defects);
- the rejection of, or late, pre-natal care by pregnant adolescents and a non-adherence to a well-balanced diet producing a greater likelihood of complications (e.g. toxemia, pre-maturity, infant mortality);
- not desiring to be pregnant creating stress for the mother-to-be and affecting the health and happiness of the child-to-be, if this attitude continues;
- the lack of education and limited job experience reducing the occupational opportunities and level of income;
- the increased likelihood of living in subsidized, substandard and overcrowded housing;
- the lack of parenting preparation contributing to the potential for child abuse and neglect;
- the reliance on multiple caregivers providing inconsistent care.

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[16] See for example, Judith Bemis, Evelyn Diers and Ruth Sharpe, "The Teenage Single Mother," Child Welfare LV (5) (May 1976): 310; Jo Billung-Meyer, "The Single Mother: Can We Help?" The Canadian Nurse 75 (10) (November 1979): 26; Frank G. Bolton, The Pregnant Adolescent: Problems of Premature Parenthood (Beverley Hills, California: Sage Library of Social Research, 1980), pp. 147-170; Anne McCreary Juhasz, "To have or Not to Have - Children? That is the Question," Journal of School Health XLIII (10) (December 1973): 633; Chatelaine, "Childbirth in the 1980's," (November 1981), p. 136; Big Sister Association - Huntley Youth Services, The Adolescent Parent in Toronto, by Faye Mishna (September 1980), p.2; The Toronto Star, "Mom's State of Mind helps shape Baby-to-be," by Paul Darby (November 7, 1981), pp. H 1-2.

Given the lack of agreement regarding the parenting capacity of unmarried mothers and the recommendation from the Operational Review, the Ministry of Community and Social Services decided to embark on a survey of maternity homes as the basis for a review of their programs. This purpose received added impetus from the subsequently announced plans by the Ministry of Health to improve the maternal and preparation for parenthood services provided by individual Boards of Health. A high priority is appropriate counselling, referral and follow-up for pregnant women identified as being at risk or high risk. To what extent maternity home programs for unmarried mothers will supplement the proposed program of the Ministry of Health still remains to be seen. Consequently, the expansion of service by the Ministry of Health is an important new element to be considered by maternity homes and regional staff in their ongoing review of services for this population.

The survey was also undertaken to assist the individual home and the Ministry Area Office in the development and review of their annual program and financial plans. As part of the funding transfer from The Charitable Institutions Act to The Children's Institution Act it was agreed that an annual program and financial plan would be developed by each home. In preparing this plan the service providers are encouraged to engage in a process in which they critically assess the appropriateness of their programs in terms of their stated goals and objectives and consider the viability of alternative programs in order to more effectively serve their client population. Clearly, an overview of the situation of all maternity homes as well as availability of other services is critical for effective planning and planned changes.

This study was also initiated to provide direction for the development of a policy regarding the future services and funding of adults receiving service from a maternity home — a children's residential facility. The Operational Review: Children's and Youth Institutions recommended that the funding of maternity homes be moved from The Charitable Institutions Act to The Children's Institutions Act in order to allow for more flexible funding in terms of the proportion subsidized by the province and to grant the homes an increase in their per diem ceiling of $17.50. While traditionally maternity home service has been available to pregnant unmarried women over the age of 21, the changes in social attitudes and the development of possible non-residential services called into question the continuation of the earlier policies. Consequently, the transfer of funding was approved on the condition that the Ministry review the circumstances of the over-21 year old residents.

To summarize, the purposes of the review of maternity homes were as follows:

- to document the types of programs provided by maternity homes and to relate these to the longer term role of maternity homes;
- to determine if the unmarried pregnant women who use maternity home service are at risk for parenting problems;
- to assist the individual homes and the Ministry Area Offices in the development and review of their annual program and financial plans;
- to provide direction for the development of a policy regarding future services and funding of adults receiving service from a maternity home.

## III PROCESS AND METHODOLOGY

All thirteen homes across the province were selected for the review. They are as follows:

- Armagh, Mississauga (Armagh)(17)
- Bethel Home, Toronto (Bethel)
- Humewood House, Toronto (Humewood House)
- Rosalie Hall, Toronto (Rosalie Hall)
- St. Martin's Manor, Hamilton (St. Martin's Manor)
- St. Mary's Home, Ottawa (St. Mary's Home)
- St. Monica House, Waterloo (St. Monica House)
- The Salvation Army Bethany Home, Toronto (Bethany)
- The Salvation Army Bethany Home, Ottawa (Bethany)
- The Salvation Army Bethesda Centre, London (Bethesda)
- The Salvation Army Florence Booth Home, Thunder Bay (Florence Booth)
- The Salvation Army Grace Haven Home, Hamilton (Grace Haven)
- Victor Home, Toronto (Victor)

Traditionally, all of these homes provided a maternity home service; however, two of the homes - Armagh and Humewood House - now operate primarily as group homes for troubled adolescents, although they still accept a limited number of pregnant girls. It was agreed, nonetheless, to include these two homes in the study in order to provide a broader picture in terms of programming and characteristics of the population.

Letters were sent to the directors introducing the study and inviting them to participate. In addition, a presentation was made at the Maternity Home Association meeting in January 1981. All 13 homes agreed to cooperate in this research endeavor. The Ministry is particularly appreciative of the participation of St. Martin's Manor, Hamilton recognizing that this home, unlike the remainder, does not receive funding from the provincial government. Thereafter, a schedule was arranged for February and early March 1981 to interview the director of each home, to interview the pregnant residents and new mothers who agreed to participate and to collect data on a sample of former residents. A pre-test was conducted late January 1981 at Victor Home in Toronto.

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17 Armagh no longer provides a maternity home service.

## 1. The Directors

A guide was developed for interviewing Maternity Home Operators. Topics of discussion included: information on admission, referral sources and eligibility criteria; a profile of the pregnant women, identifying changes in the characteristics of residents over time; programs offered by the home and by other groups in the community; the organizational structure of the home, including staffing and board involvement, where applicable; and financial information, including examination of sources of revenue such as contributions from residents (or parents). After the interviews with the residents were completed, meetings were held with the Maternity Homes Association, which has representation from 11 homes, and with the Research Committee of this Association. This consultation process was helpful in clarifying and in providing additional information on the profile of the residents and the homes' programs.

## 2. The Residents

- Sample

All maternity home residents were invited to participate in the study with the following exceptions. In homes where there was a mixed population of pregnant and non-pregnant residents, only the pregnant ones were interviewed. And, in homes which accepted non-residents in addition to residents, only the residents were included in the study. Finally residents who had already given birth were interviewed as well.

Participation in the study was voluntary. The results indicate that a total of 87% of all maternity home residents who met the inclusion criteria participated in the research (N = 141 of 163 residents). The remaining 22 residents did not participate for the following reasons: demands of school or work, doctor's appointments, absent from the home at the time of the interview and/or perhaps an unwillingness to participate in the study.

Each resident was interviewed individually. In order to maintain consistency throughout, the same researcher interviewed all of the residents. The questionnaires were completed by this researcher.

- The Questionnaire

The questionnaire used for the residents was drafted beginning in the fall of 1980 by Ministry staff in consultation with several program supervisors who were responsible for maternity homes and related children's aid societies. The draft was shared with the directors of the maternity homes and was pretested at Victor Home.

The questionnaire includes both closed-ended questions pre-coded for computer purposes and open-ended questions designed to elicit more descriptive responses. Many questions are specific to the individual, such as personal identifying information, educational background, financial information and work experience, family and friends, living arrangements, health information and future plans. In addition, this instrument sought to examine other issues such as the extent to which residents (or other persons/agencies) contribute to the home.

- Consent Forms

The residents were asked at the completion of the interview whether they would like to participate in a follow-up study, should one take place. Those who agreed to be involved signed a consent form. A total of 65% of all residents (N = 91 of 141) gave consent. In general, these residents were not representative of the total maternity home population. Those who did not sign the form appeared to be more "middle class" than the others, were from more stable family situations and were in the maternity home to conceal their pregnancy from relatives and friends, with the plan of relinquishing their baby for adoption. It was felt that they wanted to forget this experience as much as possible and in turn, were not receptive to future questioning.

## 3. The Former Residents

- Sample

A sample of former residents was derived from the caseload of pregnant residents who were admitted to the homes during the period January 1, 1979 to December 31, 1979. Specifically the file of every third person on the intake list was included in the sample providing that this procedure resulted in a sample size of at least 10 for each home. In cases where the total was less than 10, every second file was pulled or where necessary, the file of every person was examined. The sample of former residents consisted of 245 individuals from 12 homes. The remaining home, Armagh did not have any former resident files due to their shutdown for a brief period of time last year.

The data on the former residents was collected by either an official of the Ministry or by the staff of the maternity home. Some of the directors expressed concern regarding a Ministry person having access to these files and consequently, they chose to complete the data collection forms themselves. In other cases, it was agreed that this task could be done much more readily by staff of the home rather than by an outsider, unfamiliar with the filing system and the clients. These homes, as well, opted to collect the data themselves. Having several different people collecting the same information has resulted, to an unknown extent, in inconsistency in responding to some of the questions of the questionnaire.

- The Questionnaire

The information on the former residents was based on an intake form which is used by most of the homes. The data collection form includes personal information such as age, place of birth and education, referral sources, the residents' involvement with other community agencies and plans for the baby. Like the questionnaire for the residents, this form was prepared in consultation with other Ministry people and with maternity home operators. It too was pretested.

Despite the effort to perfect this instrument, some of the questions were found to be inappropriate whereas others did not elicit useful information. Problems were mainly with the questions relating to the completion of post-secondary education, living arrangements before entering the home, the source of income while in the home, involvement with other social service agencies in the community while in a maternity home and follow-up with a resident since the child's birth. In addition, some data on the former residents are missing because the information was not in the case records and a follow-up of the cases with the directors (or other staff) was not done. In interpreting this data, it is important to remember that this information reflects the maternity home directors' or social workers' perceptions and understanding of the residents' situation.

## 4. Limitations of the Study

While the consultation process and the pre-test revealed some problems with the questionnaire, which were then corrected, others were identified during the interview process.

The first problem which might be expected in a standardized questionnaire covering varying social and cultural backgrounds was a form of middle class North American bias which was built into the questionnaire. This bias was most evident in questions dealing with the family unit and family stability. The questions were too few to provide a complete summary of the variety and range of family arrangements experienced by some of the residents.

For example, residents were asked the marital status of the persons with whom they mainly lived while they were growing up, assuming that in most cases these persons would be their parents. However, several residents had lived with many different relatives, foster parents, etc., in their childhood for varying lengths of time. Due to the limited number of choices in the questionnaire, the responses to this question reflected a type of stability that in fact did not exist for some respondents. And if in fact the residents lived with both parents, this in itself did not provide sufficient information with which to draw conclusions about family stability.

A further illustration of this bias was obvious in the question on birth order. In particular, a resident might have been the second of the father's seven children, first of the mother's three, and eldest of the adoptive or foster parent's four children. The range of responses to this question, however, did not allow for such answers. Therefore, definitive judgements about family relationships cannot be made.

The second problem relates to identifying the notion of high risk through the questionnaire. Having been forewarned that some residents in maternity homes would be very reluctant to provide information of a personal nature, it was felt that the direct questions such as on the use of illegal drugs or the identification of mental health problems would not be well received by the respondents and might not be answered fully. Instead, indirect questions (e.g., past living situations, marital status of parents with whom the residents mainly lived, pre-natal medical visits, condition of health and the resident's involvement with various social service agencies) were designed. These kinds of questions, however, were ineffective in tapping risk.

To illustrate, it became clear to the researcher during the interview that despite a resident's non-involvement with a social service agency, she may have been experiencing a problem (e.g. excessive alcohol consumption). The questionnaire was not effective in identifying this high risk situation. In other cases, a resident may have indicated an involvement with a social agency (i.e. the children's aid society); however, this contact may not have evolved from her inherent problem but rather may have resulted from a routine referral procedure between the maternity home and a children's aid society. So in this example, the questionnaire would have shown a high risk situation that did not exist. In addition, the data are self-reported and in order to accurately establish high risk, it would have been necessary to corroborate this information with early childhood experiences (e.g., being a victim of child abuse). Presumptions of high risk, therefore, need to be qualified by these limitations of the questionnaire.

In order to have a better assessment of high risk, a risk index was constructed. This index combined variables which were found to be indicative of potential risk. Limitations to this instrument are discussed under the section on high risk.

# IV FINDINGS

## 1. The Profile of Maternity Home Residents

The profile of the typical maternity home resident is based on the data obtained from the questionnaires administered to the residents during face-to-face interviews in February and March 1981 (N=141), on the information derived from the data collection forms based on the case file notes of a sample of residents in 1979 (N=245) and on the directors' impressions recorded during personal interviews. Where possible, comparisons are made with the profile of maternity home residents in Ontario (N=246) developed by Lightman and Schlesinger in 1978.(18) The information is reported under three headings: demographic or individual characteristics, social variables and medical or health related factors. This portrayal describes the types of women who enter a maternity home and hopefully can be used by maternity home administrators in reviewing their present combination of programs.

**Demographic Characteristics:**

The directors of the maternity homes reported that the residents currently seeking admission are younger than in the past. Even in the three years from 1978 to 1981 there was a slight drop in the average and modal age of the residents. Lightman and Schlesinger found that the average age of the residents in their sample population was 19 years. The residents in the 1979 and 1981 Ministry survey were on the average 17.9 and 17.8 years old, respectively. In terms of the modal age, the 1978 and 1979 residents were typically 17 years of age and the 1981 women were 16 years old. This trend is the reverse of that among unwed pregnant teenagers in general in Ontario in which the modal age of mothers for all births out-of-wedlock increased from 18 years in 1979 to 19 years in 1980.(19)

Most of the residents in these three samples were adolescents, 15 to 19 years of age. The following table shows the percentage of residents in each of the various age categories.

Age of Maternity Home Residents

| Age Category<br>(Years) | 1978(N=246)<br>(%) | 1979(N=245)<br>(%) | 1981(N=141)<br>(%) |
|---|---|---|---|
| 15 | 0 | 3.7 | 4.2 |
| 15-19 | 73 | 75.9 | 75.9 |
| 20-24 | 23 | 17.1 | 14.9 |
| 25+ | 4 | 3.3 | 5.0 |
| | 100 | 100 | 100 |

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[18] Ernie S. Lightman, "Intake at Maternity Homes in Ontario: A Descriptive Analysis," Toronto, n.d. (mimeographed), pp. 1-28.

[19] Ontario, Office of the Registrar General, Vital Statistics, 1979 and 1980.

The increase in the younger resident is accompanied by a decrease in the women 20 years and older. Most of the older residents in these samples were in their early or mid-twenties. Few of them were in their late twenties or thirties. (See Appendix 1, Table 1 for further details). The reason for the limited number of older residents is the result of several factors: maternity homes in recent years have been geared to the teenage population and have been planning their programs based on the needs of this age group; the older women are carefully assessed at intake to determine whether or not they would be compatible with the rest of the residents; and older women do not seek admission into maternity homes as readily as the younger ones.

The majority of residents had never been married (90.6% in 1979 and 95% in 1981). Similarly, Lightman and Schlesinger found that virtually all of the residents in their sample (98%) were single. The remainder were separated, divorced or had been living common-law.

In terms of religious affiliation, most of the residents in 1979 and in 1981 were Catholics or Protestants although a slightly greater proportion of them were Catholic. Similarly in 1978, just over half reported their religious preference to be Roman Catholic. The next largest religious group was reported to be Protestant. The following table shows the breakdown of the three samples of residents by religious preference. The Catholic's utilization of maternity home service is likely to be a reflection of the higher rate of carrying their pregnancy to term resulting from a non-acceptance of contraception and abortion. There are no admission restrictions respecting the individual's religious affiliation.

**Religious Preference:**

| | Ontario Population | Maternity Home Residents | | |
|---|---|---|---|---|
| Religious Affiliation | 1971 Census N=7,703,105 | 1978 (N-246) | 1979 (N-245) | 1981 (N=141) |
| | (%) | (%) | (%) | (%) |
| Catholic | 34 | 58 | 40.0 | 42.6 |
| Protestant | 55 | 39 | 35.5 | 40.4 |
| Other | 6 | ) 3 | 9.0 | 4.9 |
| | | ) | | |
| No Religion | 5 | ) | 0.2 | 11.3 |
| No Information | 0 | 0 | 14.7 | 0.7 |
| | 100 | 100 | 100 | 100 |

About half of the residents in 1979 and in 1981 had resided in a county other than that of the maternity home before entering the home. This finding is not surprising since the 13 homes are clustered in only seven of the more than 50 counties in Ontario. Based on this, it is evident that many women would have to leave their county of origin to avail themselves of the maternity home service. Furthermore, a number of residents came from small towns in other counties presumably because out-of-wedlock pregnancy is still not socially accepted in those communities. A slightly smaller percentage of the residents (around 40%) had lived in the same city as the maternity home prior to admission.

Few of the residents had lived in another province or country immediately prior to admission. This data is substantiated by the directors' impressions that almost all of their residents are from Ontario. In fact, they stated that many referrals are from their local community or outlying areas, within Ontario. The only exception is St. Mary's Home in Ottawa which accepts between 20% to 50% of its referrals from Quebec. Women from outside Canada seeking admission are required to have landed immigrant status.

The majority of residents in 1981 and in the 1978 survey (60% and 66%, respectively) lived in a two-parent family. The questionnaire did not provide for information on whether these parents were the residents' natural, adoptive, step or common-law parents nor did it allow for data assessing the quality of the relationships. The directors, however, added that these family units are often characterized by unstable conditions (e.g. family conflict, marital disputes, overcrowding).

A substantial portion of the residents (40% in 1981 and 34% in 1978) lived in a one-parent family resulting from parental separation, divorce or death. The following table shows the percentage breakdown. This proportion of one-parent households is about four times greater than that for the total population in Ontario.(20)

Types of One-Parent Family Units in which Residents Mainly Lived

| | 1978 (N=246)<br>% | 1981 (N=141)<br>% |
|---|---|---|
| 1 Parent Unit resulting from: | | |
| Separation | 22 | 13 |
| Divorce | 16 | 17 |
| Death | no information | 10 |
| TOTAL | 38 | 40 |

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[20] In 1976 there were 2,104,540 families and 202,450 lone parent families which is about 10% of all family units. Source: Statistics Canada, Census Information 1976, Catalogue Numbers: 93833 and 93821.

Almost two-thirds (62%) of the residents sampled in 1981 were students prior to entering the home. This percentage was fairly consistent among the four regions in Ontario (Central, Southwest, Southeast, and North). In comparison, the 1978 study sample indicated that just under half (49%) were registered in school at the date of intake. The table below shows the program of studies in which these two samples of residents were enrolled and their average grade of enrollment. The directors commented that the grade reported by the residents was often inflated. Their assessment of the residents' ability indicates that many of them were at a lower educational level than they reported.

Education of Residents who were Students

| | 1978 (N=120)<br>% | 1981 (N=88)<br>% |
|---|---|---|
| Program of Studies: | | |
| General (Academic) | 78.0 | 79.5 |
| Secretarial | no information | 10.2 |
| Other Vocational | 10.0 | 8.0 |
| Other | no information | 2.3 |
| | 88 | 100 |
| Average Grade of Enrollment | 11 | 10.6 |

Three-quarters of the 1981 residents continued with or resumed their education during their stay in the maternity home. Of these residents, the majority (84.5%) attended the school program offered by the home and the remainder (15.5%) either attended a school in the community or enrolled in a correspondence course.

An overwhelming proportion (85.6%) of the 1981 residents who were students stated that they intended to continue with their schooling following the birth. However, other studies have shown that early childbearing is strongly associated with a lower educational attainment and is the leading cause of school dropout among females in the early grades of high school.(21) Furthermore, relatively few young mothers who plan to continue their education actually return to school.(22) Another study on dropout found that a student who stays out of school for whatever reason for more than a year will probably not return.(23) On the other hand, the fact that more of the residents of this study intended to resume their schooling may be because they are younger than the unwed single women in the general population or because of their positive experience as a student in the individualized in-home education program.

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[21] Prince Edward Island, Department of Agriculture and Forestry, Women's Institute Program, A Challenge from a Changing Lifestyle: Adolescent Parenthood in Prince Edward Island, by Brenda MacAdam (n.d.), p. C1.

[22] Ibid., p. C2.

[23] The Board of Education for the City of Toronto, Study of Returning Students Part III: Characteristics, Opinions and Experiences of Returnees and Non-Returnees, by Sylvia Larter and Maisy Cheng (December 1979), p. 36.

The following table illustrates the average grade of attainment and the average and modal ages of the other residents who were not attending school prior to admission.

Education of Residents who were Non-students

| | 1978(N=125) | 1981(N=54) |
|---|---|---|
| Average grade Attained | 10.8 | 10.1 |
| Average age when left school (years) | 17 | 16.5 |
| Modal age when left school (years) | 16 | 16 |

Very few of the 1981 residents who were 18 years or older had graduated from high school at either the Grade 13 level (1.7%) or at the Grade 12 level (12.2%). In comparison, 8% of the 1978 non-student residents were at the post secondary school level. These findings suggest that most of these women had low educational goals and poor educational achievement prior to their becoming pregnant.

In terms of employment, slightly more than half (56.7%) of the residents in the 1981 sample had worked immediately before their pregnancy and almost two-thirds (65.2%) had worked in the last year. Of this latter group, approximately one-third (35.9%) had worked mainly full-time and about two-thirds (64.1%) had worked mostly on a part-time basis. Typically these positions were in the service sector (e.g. as a waitress). Half of the residents who had worked in the last year held only one job. Almost one-fifth (19.6%) had two positions, another one-sixth (15.2%) had three jobs and the remaining proportion (15.2%) had three or more jobs. Most of these persons (58.7%) earned under $100 a week. A smaller proportion (37%) earned a weekly salary between $101 and $200. Very few (3.3%) made more than $200 a week.

Few of the residents (6%) worked during their stay in the maternity home. Following discharge from the maternity home, 12% indicated that they would like to work full-time and 9% intended to work part-time. However, a greater proportion (38.3%) did not plan to work but instead planned to collect public assistance. Dependence on public financial support may not have been desirable for some of the women; however, it may have been their only option, especially if they were planning to keep their babies.

**Social Variables:**

One of the factors that is assumed to be important during the child bearing and child rearing period is support (eg. emotional, housing, financial and child care). There are two major sources of support - informal and formal. An informal support network includes family, the boyfriend or husband and friends whereas the formal support system includes professionals and social service agencies. The examination of support during and after pregnancy provides a preliminary assessment of isolation experienced by residents.

- Informal Support

  Prior to their admission in the maternity home, more than half of the residents of both samples lived with their parents (57.1% in 1979 and 58.9% in 1981). Although the 1978 response is not entirely comparable, about three-quarters (73%) reported that their permanent home was with their parents, though this need not be equated with living at home with their parents prior to admission. The rest of the residents lived with the putative father, other relatives, friends, by themselves, in another maternity home or elsewhere.

  Following discharge from the maternity home fewer (48.6%) 1981 residents planned to live with their parents which may reflect a loss of their support or may just reflect the cultural norm of setting up a separate home. Nonetheless, residing with parents following the birth was still the most common plan. The proportion of residents planning to live on their own, (18.5%) was greater than that of those living alone prior to entering the home (5.7%). A number of respondents (11.4%) gave no information.

  The majority of the younger residents lived with their parents prior to admission and were planning to live with them following their discharge from the maternity home. In contrast, a smaller proportion of residents over 19 years of age had lived and were intending to live with their parents. The following table shows the age breakdown for this type of living arrangement. (For details on age related to other types of accommodation see Appendix 1, Tables 2 and 3).

Age of the Residents by Prior and Intended Residence with Parents (1981)

| | 16 (N=21)<br>% | 16-18 (N=83)<br>% | 19-20 (N=19)<br>% | 21+ (N=18)<br>% |
|---|---|---|---|---|
| Lived with Parents prior to Admission | 66.6 | 65.1 | 47.4 | 33.3 |
| Intended to Live with Parents following Discharge | 57.1 | 55.4 | 31.6 | 22.2 |

While in the maternity home, more than one-third (36.2%) of the residents of the 1981 sample population received visits once a week and about one-fifth (20.5%) received visits one or two times a month. A smaller proportion (13.5%) claimed that they received visits sporadically. Almost 30% of the residents indicated that they had never received visitors. Of this latter group, 30% had been in the home for one to two weeks which may explain why they had not received any visitors. However, 70% of that group had been in the home longer than two weeks of whom 20% were in the home three to six weeks, 40% in the home seven to 16 weeks and 10% in the home 17 weeks or longer. This suggests that they may be isolated from significant other persons.

In terms of leaving the home to visit family or friends, a fifth (19.8%) of the residents indicated that they made visits ten or more times a month. About a third (34%) visited family or friends three to nine times a month. Approximately one-fifth of the residents (19.1%) left the home to visit others only once or twice a month.

It is noteworthy that a substantial proportion of residents (27%) did not respond to this question of leaving the home to visit family or friends. Forty percent of them had been in the home for one to two weeks. For them, the question may not have been relevant. The other 60% who did not respond to this question had been in the home at least three weeks and reportedly had not left the home to visit anyone. It may be that they had no one to visit and did not want to reveal their isolation to the interviewer.

The residents' perceptions of the attitudes of other persons (i.e. the putative father, parents and friends) toward their pregnancy were coded, where possible, into a five point scale as follows:

- actively negative (e.g. an expression of anger, denial, shock or disgust);
- not supportive (e.g. apathetic, disappointed, indication of differential treatment, no indication of acceptance or support);
- both actively negative and supportive;
- accepting (e.g. understanding, accepting or come to accept, no evidence of differential treatment but no indication of support);
- supportive (e.g. helpful, supportive, thrilled).

The following table shows the percentage breakdown for this continuum.

Residents' Perception of Other People's Attitudes toward their Pregnancy (1981)

| | Putative Father (N=144) (%) | Parents (N=141) (%) | Friends (N=141) (%) |
|---|---|---|---|
| Actively Negative | 24.1 | 8.5 | 2.8 |
| Not Supportive | 13.5 | 10.6 | 16.3 |
| Both Unsupportive and supportive | 11.3 | 10.6 | 9.9 |
| Accepting | 5.7 | 15.6 | 18.4 |
| Supportive | 12.8 | 19.1 | 29.8 |
| TOTAL* | 67.4 | 64.4 | 77.2 |

* The totals do not add up to 100% because other categories (e.g. initially actively negative followed by accepting or supportive or uncodeable responses) have been omitted from this table.

It is apparent from this table that the residents perceive the putative father as opposed to parents or friends to be least supportive of the pregnancy. On the other hand, parents and particularly friends were seen by the residents as being more accepting and supportive of the pregnancy. In additon, there was a tendency on the part of the parents to change their attitude from being actively negative initially to being either accepting or supportive. This change was reported by one-fifth of the residents. While few lack support from all these sources, it can be seen that quite a few residents face negative attitudes toward their having a child.

• **Formal Support**

The 1981 referral statistics(24) indicate that the largest source of referral was self or family and friends. This constituted more than one-third (36%) of all referrals. The number of self-referrals, according to the directors, has grown in recent years which suggests for example that more unwed women are becoming aware of maternity home service. This awareness comes from friends and relatives who had been or had known others who had been in a maternity home. Some of these women have not sought assistance from other agencies or professionals. For them, the maternity home represents the first point of contact with the social service system. Other women may have been seen by several agencies and professionals but did not maintain contact with them for a long enough period to be referred by them.

The next largest source of referral (21%) was the children's aid societies. While the children's aid societies are still a major source, the proportion of referrals from them has decreased over the last few years. The Lightman and Schlesinger study notes that these agencies were the largest referral source in 1978, comprising 30% of all referrals. The decline in the number of these referrals parallels a trend that fewer unmarried women are seeking service from the children's aid society. Their unmarried caseload was reduced significantly from 9,798 in 1969 to 4,313 in 1974 and to 2,943 in 1979.(25)

Other sources of referral were schools, organizations, etc. (21%), other social services agencies such as Birthright and hostels (17%), a nurse or doctor (13%), the clergy (9%) and Probation and Aftercare (less than 1%). With the exception of the clergy, which used to be a prime source of referral, these other sources have only been referring women to maternity homes in recent years. This reflects the changes in society in which the more traditional services and structures are becoming less important to unmarried mothers and are being replaced by new or different organizations. In addition, the relatively recent strong pro-life movement, which has accounted for a significant number of pregnant women choosing to carry their baby to term, has contributed to the increased number of referrals from Birthright, etc. These sources of referral represent the new sources of information available to unwed pregnant women.

In terms of utilization of social services, relatively few (7.1%) indicated that they had been receiving assistance from the welfare department. A smaller portion of residents claimed that they had been receiving counselling (5%), mental health services (3.5%) or probational services (1.4%).

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[24] Multiple responses to this question were provided.

[25] Doris E. Guyatt, "Children Raising Children".

Despite their limited involvement with agencies at the time of the interview, more than one in four (27.9%) of this sample population had been a ward of a children's aid society at some point in time. A much smaller proportion (1.4%) had been a ward within the juvenile correctional system. Of the former group, slightly more than half (55%) were made wards during their teen years. A third (33%) were made wards for one year or less, 15.4% for one to two years and more than half (51.3%) for more than two years.

**Medical and Health Related Factors:**

The majority of respondents (75%) in the 1981 survey perceived themselves to be in excellent or good health. Only a small percentage (2.8%) considered themselves to be in a poor condition. The remainder stated that their health was fair. Those self-reports do not agree with the perceptions of the directors of the homes. They noted that, from their experience, the residents within the last several years have been experiencing more health problems. Their staff also have had to become more assertive in ensuring that the residents keep their doctors' appointments and follow their treatment plans. They commented that the residents often deny any health problems, forget they have any problems because they are being cared for while in the home or may not associate problems relating to the pregnancy (e.g. high blood pressure, toxemia) as health problems. A number of directors, therefore, questioned the validity and reliability of residents, particularly adolescents, reporting their own health. In support of the directors' impressions, the 1978 profile of maternity home residents obtained by Lightman and Schlesinger noted that 14% of the respondents had some serious illness or handicap.

The directors also noted that the residents, of late, have more psychological problems than the residents in the past. The directors' impression was substantiated by the 1978 maternity home study which found that 26% of the residents had received psychiatric treatment at one time or another.

Related to the health of the residents is the concern about pre-natal care, namely medical visits. A number (9.2%) claim they saw a doctor in the first month of their pregnancy and more than half of the residents (53.2%) saw the doctor in the first trimester. Only 2.9% waited until the seventh or eighth month for their first doctor's appointment. Research on pregnant adolescents shows that many of these women do not seek medical care until the middle or even the final trimester of their pregnancy.(26)(27) This delay has often been interpreted as a denial of their pregnancy, a fear that doctors will strongly recommend that they have an abortion or ignorance by young women regarding the importance of medical care. Given that many of the maternity home residents seek medical care early in their pregnancy, which is contrary to the research findings on pregnant adolescents in general, it is the directors' impression that the pregnancy was a planned event for a number of them. On this basis, it seems that some of the maternity home residents may be different than the general population of unwed pregnant women.

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[26] Social Planning and Review Council of British Columbia, An Overview of Teenage Pregnancy and Parenthood in British Columbia, by Cathy Adler and Shirley Congdon (September 1980), p. 5.

[27] Prince Edward Island, op.cit., pp. A2-8.

While this data suggests that many of these pregnant women sought medical attention at an early stage of their pregnancy, the questionnaire did not follow-up on this information and so it is not possible to draw any conclusions about their health or the purpose and thoroughness of these early medical contacts. For example, it is unclear whether the residents had continuous medical attention beyond the initial visit. In addition, there is no information to determine whether or not they had a physical examination, received nutritional counselling, etc. during their visit or merely had a pregnancy test.

In addition, this questionnaire does not ask the residents why they saw the doctor initially, that is to say whether they wanted to confirm their pregnancy and begin pre-natal care or whether they were required to see a doctor as one of the pre-admission procedures of the home. A comparison between the month the residents saw the doctor for the first time and the month they applied for admission illustrates that the majority (60%) of the respondents saw the doctor for the first time at least one month prior to their making application to the home while fewer (40%) saw the doctor initially during the same month of applying for admission or later.

The decision to seek pre-natal care early in their pregnancy and prior to their applying to a maternity home suggests that some may have planned their pregnancy. This desire of some residents to be pregnant was noted by the directors. They added that the pregnancy was a planned event especially for those who had a previous pregnancy which was either aborted or if carried to term resulted in relinquishment of the baby.

The data on the residents' number of previous pregnancies reveal that the majority (88.7%) of the 1981 sample claimed that the pregnancy was their first. Similarly, Lightman and Schlesinger found that 87% of the respondents reported that this was their first pregnancy. They questioned, however, the accuracy of this response, although they did not give any basis for their doubts. If there was underreporting, it could relate to the timing of this sensitive question as it was asked at intake.

The outcome of the previous pregnancies of those 1981 and 1978 residents for whom this was not their first pregnancy is shown in the following table. In the 1981 sample, more of the residents (40.9%) carried their pregnancy to term. About half as many (22.7%) chose to abort their pregnancy. In contrast, the majority of the 1978 residents (60%) terminated their previous pregnancy and a much smaller proportion of that sample (28%) carried their pregnancy to term. The variation in reported outcome by these two samples of residents is surprising. Given that the findings so far have demonstrated similarities on most variables between these two populations, it is difficult to understand this variance. Nonetheless, the number of residents who claimed they had a previous pregnancy is too small for conclusions to be drawn.

### Outcome of Previous Pregnancies

| | 1978 (N=25) (%) | 1981 (N=16) (%) |
|---|---|---|
| Carried previous pregnancy to term | 28 | 41 |
| Aborted pregnancy | 60 | 23 |
| Miscarried | 12 | 32 |
| No information | 0 | 4 |
| | 100 | 100 |

The fact that for the majority of residents this pregnancy is reportedly their first raises the likelihood of future pregnancies. Other studies have shown that there is a high incidence of subsequent pregnancies among adolescents. One study, in particular, concluded that women who were under 20 years of age during their first pregnancy had more subsequent births than women who were older than 20 years at their first confinement.(28) This positive relationship between age and rate of fertility may exist for maternity home residents, as well. It is uncertain to what extent the young maternity home residents will have additional births. This situation underscores the need to provide programs which are aimed at preventing subsequent unplanned pregnancies. This is one of the objectives of all maternity homes.

The residents' knowledge and use of birth control was examined as well. The data show that all the residents had learned about birth control. More than two-thirds of them (68%) claimed that they had acquired their knowledge through schools. However, more than three-quarters had not practised any method of birth control. Most of these respondents were 18 years and younger. Of those who did use birth control (approximately 20%), 65.5% indicated that they used oral contraceptives, followed by 31% whose boyfriends used condoms. The others resorted to alternate methods such as foam or an IUD.

A review of the research on pregnant teenagers postulates that several demographic, situational and psychological variables are associated with limited use of contraception. Examples of these variables are as follows: age, ethnicity, having infrequent intercourse, a lack of access to a free, confidential, personally reassuring family planning service that does not require parental consent, an ignorance of the risks of pregnancy, a lack of awareness of family planning services, a fear of side effects and possible infertility from contraception, a feeling of fatalism, powerlessness, alienation, and/or incompetence.(29)

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[28] Mignon Sauber and Eileen M. Corrigan, The Six Year Experience of Unwed Mothers as Parents (New York: Community Council of Greater New York, 1970), p. 30.

[29] Catherine Chilman, op.cit., p.494.

Studies on access to sex education and contraception services demonstrate that increased knowledge and provision of services reduces the pregnancy rate ie. the number of births and abortions.(30)(31) This lack of planned parenthood suggests that more preventative work on family planning needs to be undertaken by relevant professionals and agencies especially the schools who are the major source of knowledge for these women. However, if the pregnancy is a planned event, then the approaches to preventing pregnancy become more complex and have to deal with other issues than increased knowledge of sex education and a greater access to contraception services. These other issues could include such things as low self-esteem, poor family relationships and emotional deprivation.

## 2. High Risk

The profile of maternity home residents sampled in 1981 indicates that they are not a homogeneous group. There is variation in terms of their demographic characteristics, support networks, involvement with other agencies and medical and health related factors. It appears that some of the residents may be at risk based upon the literature on teenage pregnancy and motherhood briefly discussed earlier. The following summarizes the inferences related to risk from this survey:

- The majority of residents (75%) were young, 15 to 19 years of age. Based upon the literature on teenage pregnancy and motherhood, adolescence is one of the key factors negatively affecting the well-being of the mother and the child.
- About one-third were not enrolled in school prior to admission into the maternity home. On the average they quit school before their 17th birthday and attained a grade 10 level of education.
- The jobs which most residents held in the year preceeding their admission into the home were typically part-time positions in the service sector providing weekly earnings of less than $100. Half of these residents held more than one job during this one-year period.
- While few residents lived alone prior to their admission into the home, almost 20% intended to live alone following their discharge.
- About 30% of the residents never received any visitors while in the home and 20% left the home to visit family and friends only once or twice a month.
- About a third of the residents perceived that other significant persons, mainly the putative father, had an actively negative attitude toward the pregnancy.
- A few residents had been using social services in the community for counselling, treatment or protection prior to their admission into the home.

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[30] Planned Parenthood Ontario, Adolescent Birth Planning Needs: Ontario in the Eighties, by Maureen J. Orton and Eileen Rosenblatt (January 1981), pp. 49-50.

[31] Diane Sacks, "Pregnancy Among Teenagers", Canadian Medical Association Journal 124 (April 15, 1981): 960.

- More than one in four residents had been a ward of a children's aid society.
- A quarter of the residents perceived themselves to be in fair or poor health.
- Just less than half saw the doctor for the first time in the second or third trimester of the pregnancy.
- About 10% of the residents claimed that they had at least one other previous pregnancy.

On the basis of these findings, it appears that a number of the unwed mothers-to-be and their children-to-be may be at risk. In order to summarize the extent of risk for each individual in this population, a risk index was constructed, by combining those demographic, social and medical variables which have been found to reflect risk. In order not to exaggerate risk, only very clear indicators of risk were selected. As a result, the amount of risk determined by this index is a very conservative estimate.

The risk index consists of seven subindices: risk age, risk education, risk work, risk isolation, risk agency involvement, risk health and risk previous pregnancy. Risk health, for example, includes residents who reported their health to be fair or poor and residents who saw a doctor for the first time either in or after the fourth month of the pregnancy. A score was assigned to each of these conditions, as follows: fair health was given a score of one, poor health was given two points, a first medical visit in the second trimester equalled one point and a first check up in the third trimester was given a score of two. The maximum score for this section of the index was four. A description of each of the other subindices is available in Appendix 2.

By combining information from a variety of different areas in a person's life, the risk index can provide a more accurate assessment of the level of individual risk. Before turning to the index, it is important to note that there are a number of problems that limit the usefulness of this instrument. For the most part, these would tend to make it a conservative estimate of risk. For example, the data is self-reported. This type of data collection resulted in inaccurate or missing responses which were most evident in the areas of social isolation, agency involvement and health. Specifically, residents may have had difficulty in acknowledging and/or revealing that they receive little support from family and friends or in reporting their involvement with mental health facilities because of the associated stigma.

Another limitation is the fact that sensitive questions such as a history of child abuse and neglect and family relationships were omitted from the interview. It was felt that these kinds of questions would be poorly answered and likely to create an uncomfortable atmosphere in which to conduct the interview. Furthermore, the interviews were not intended to be clinical assessments of the residents and as such, they did not yield extensive personal or detailed background information.

In addition, the directors of the homes reported that the extent to which there is risk among the residents may vary from group to group. Consequently, generalizations respecting the nature of risk among maternity home residents must be made cautiously.

The index indicates that 87% of the maternity home residents who were sampled at one point in time had risk on at least one factor suggested by the literature to be indicative of risk. Summing across the subindices, the maximum score obtained by these residents was eight out of a possible 18 points. The following table shows the distribution for each possible score.(32)

RISK INDEX

| Score | Distribution of Residents (%) | Distribution of Residents (#) |
|---|---|---|
| 0 | 13.5 | 19 |
| 1 | 29.1 | 41 |
| 2 | 30.5 | 43 |
| 3 | 11.3 | 16 |
| 4 | 9.2 | 13 |
| 5 | 3.5 | 5 |
| 6 | 0.7 | 1 |
| 7 | 1.4 | 2 |
| 8 | 0.7 | 1 |
| 9-18 | 0.0 | 0 |
| | | 141 |

(Mean = 2.0)

Although the distribution indicates that no resident had a score in the high range of the scale and therefore was not severely at risk, almost one in four residents (23.4%) had a score on three, four or five of the possible seven dimensions or subindices. The following table shows the percentage distribution of residents along the seven dimensions. This suggests that the demographic, social and medical characteristics of risk, summarized earlier, are not due to a small group of severely at risk women. Instead the maternity home sample is comprised of residents who are typically at some risk, occasionally at considerable risk but rarely at extreme risk.

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[32] A high score was not possible for all respondents. Some of the elements of the risk index by definition excluded certain groups of residents. For example, risk work applied only to persons at least 18 years of age for whom stable work was possible.

Number of Dimensions on which Residents had a Score

| Dimensions | Percentage Distribution |
|---|---|
| 0 | 13.5 |
| 1 | 36.9 |
| 2 | 26.2 |
| 3 | 14.2 |
| 4 | 7.8 |
| 5 | 1.4 |
| 6-7 | 0.0 |
| | 100.0 |

The agency involvement and health subindices were the two major contributors to the overall risk index; that is to say, they accounted for most of the risk.(33) The fact that, as previously noted, residents typically fail to report their involvement with mental health agencies and their condition of health, implies that the extent of risk in the population is probably a conservative estimate. Presumably there are more residents at risk and more residents at higher risk than was indicated by the risk index.(34)

Without comparable data on unwed pregnant women in the population at large, it is difficult to interpret the level of risk in the maternity home population and to determine whether or not maternity home residents are more or less at risk than those pregnant women who do not seek maternity home service. Nonetheless, it does appear that a fair proportion of this sample - more than 20% - could be considered to have elements of risk in a number of different areas of their life. On the basis of the age factor, for which there is comparable data, the statistics do show that maternity home residents are becoming younger whereas the average age of the unwed pregnant women in the general population is increasing. According to this comparison, the maternity home residents are more at risk than the general population of unwed pregnant women. In any further research effort, it would be useful to collect data that would clearly confirm whether maternity home residents are more at risk than the general population.

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[33] The Pearson's correlation was .73 for risk agency involvement and .63 for risk health.

[34] Some of the subindices are correlated with each other, most importantly risk health and risk agency involvement ($r = 0.2$, $p < .05$). To the extent that both these indices are indicating the same underlying risk factor, for example poor health that results in temporarily placing a child in the care of a children's aid society, then including both scores could be counting the same factor twice and inappropriately so. While a cause for some concern, it seems that the two subindices are contributing independent information to the overall index. See for example the pattern of risk agency involvement and risk health data in the following section discussing the residents over 21 years of age. Based on this assessment, it seems that the risk index is a useful summary statement of individual risk, which may include some redundant information, but not enough to invalidate its usefulness.

### 3. Residents Over 21 Years of Age

While it is suggested by other research that unwed teenage pregnant women are more likely to be at risk for medical, social and potential parenting problems, the findings from this particular study show that a greater proportion of older women (i.e. 21 years of age and older) who use a maternity home service have higher scores of risk than the younger women. In fact, 50% of the residents over 21 years of age who were sampled had a score of three or more. In comparison 17% of the residents less than 21 years of age had a score of three or more. This finding suggests as well, that older women who use a maternity home service are more at risk than their pregnant peers who do not use a maternity home service.

In examining the relationship between risk and age more closely, it was evident that two particular dimensions of the index - risk work and risk agency involvement - were significantly related to age. Specifically, the residents 21 years and older as compared to those 18, 19 and 20 years of age were found to be more at risk for work problems, namely unemployment, job instability and lower weekly earnings. The residents less than 18 years, as previously mentioned were not assessed for risk work since it was considered less appropriate to make assumptions on the basis of their limited work experience. The finding that the over 21 year olds had a higher score in this area seems contradictory to what might have been expected. It would have appeared that the respondents 18, 19 and 20 years of age would have had a greater difficulty in securing steady employment. Their shorter period in the labour force would have suggested, as well, that they would have a lower level of income. This, however, was not the case.

In terms of risk related to agency involvement, more than half of the residents 21 and older had a score of one to three. This finding might be explained by the fact that these women would have had more time to come into contact with agencies and consequently, they might be more likely to seek agency help. On this basis, it seems that the risk index is biased in favour of the older residents. However, it is important to note that an even greater proportion of the less than 16 years olds (66.7%) had a similar score. The findings do show that contact with agencies was more probable among residents over 21 years of age than among residents 16 to 18 years old (40%) or among residents 19 to 20 years of age (42%). This finding further supports the notion that the older women in this sample population are a more at risk population.

The data also show that the residents over 21 years of age were more likely to have delivered their baby at the time of the interview whereas the residents less than 21 years of age were in their second or third trimesters of their pregnancy. This indicates that women at high risk receive the support service during the postnatal period as well as during their pregnancy.

## 4. Plans for the Baby

This survey questioned the residents on their intentions regarding the plans for their babies. With the exception of the 25% who had given birth and presumably had made their final decision, the majority had not given birth and therefore, their intentions may not reflect their actual decisions. Based upon the experience of the directors, the residents typically change their mind about keeping or releasing their babies for adoption. With this in mind, the data and the implications discussed below must be considered cautiously.

Slightly more residents in the 1979 and in the 1981 sample populations were planning to release their babies for adoption than to keep and raise their babies. This finding supports the study of Ontario maternity homes conducted by Lightman and Schlesinger in 1978 in which more of the residents planned to relinquish their babies for adoption as compared to those who were intending to keep their babies. The following table illustrates the percentage distribution of these three groups of residents according to the plans for their babies.

Residents' Plans for their Babies

| Plans | 1978(N=246) (%) | 1979(N=245) (%) | 1981(N=141) (%) |
|---|---|---|---|
| Release for Adoption | 51 | 40.4 | 44.0 |
| Keep and Raise | 37 | 38.8 | 43.3 |
| Keep and Someone Else Raise | 2 | 0.4 | 0.7 |
| Other | 11 | - | - |
| Uncertain | - | 14.3 | 10.6 |
| No information | - | 6.1 | 1.4 |
|  | 101 | 100 | 100 |

In comparison, the latest statistics from two out-of-province maternity homes - the Salvation Army Bethany Home in Halifax, Nova Scotia and the Salvation Army Park Wood House in Calgary, Alberta - confirm that the majority of residents release their babies for adoption.(35)(36) In Ontario, only a few maternity homes (Bethesda, Grace Haven and St. Martin's Manor) specified that the most girls release their infants for adoption. In a number of other homes (Bethany - Toronto and Ottawa, Bethel, Humewood House and Victor), the majority of girls keep their babies. Several homes (Florence Booth, Rosalie Hall, St. Mary's and St. Monica House) indicated that about half of the residents keep their babies while the other half release their babies for adoption.

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[35] Mary Burt, Administrator, Halifax Salvation Army Bethany Home, personal letter of May 26, 1981.

[36] Naida Maher, Social Worker, Calgary Salvation Army Park Wood House, personal letter of May 27, 1981.

The maternity home statistics do not parallel the current social trend. Recent Ontario figures indicate that nearly 90% of the pregnant single adolescents are keeping their babies rather than releasing the children for adoption.(37) Therefore, the maternity home residents may be seen as representing an atypical sample out of the general population of unwed mothers. Despite this, the number of residents choosing to keep their babies in recent years is growing which indicates a decreased use for adoption services and an increased need for parenting programs.

Based upon the finding from the Lightman and Schlesinger study of maternity home residents that residents intending to keep their babies appeared to be the least likely to become adequate mothers, this survey explored whether the more recent residents who were planning to keep their babies were also at risk for parenting problems. A number of similar demographic and medical related variables were examined in relationship to the residents' plans for their babies. These variables included age of the residents, educational information (e.g. enrollment in school, average highest grade completed and age when left school), marital status of persons with whom the resident mainly lived and the individual's self-reported condition of health. In addition, the plans for their babies were looked at in relationship to the risk index which combined several of these variables simultaneously. None of these relationships proved to be statistically significant at the .05 level using a chi square test. That is to say, the residents' intention to keep and raise their babies or relinquish their babies for adoption did not vary with these other variables, so that approximately 43% of the residents in any age category planned to keep and raise their babies and approximately 44% in any age category planned to relinquish their babies. The fact that these other variables did not relate to plans for the baby does not mean that these variables do not relate to final decisions regarding the baby.

Another way of determining whether the residents intending to keep their babies were more or less likely to have potential parenting problems was to compare their score on the risk index of those residents planning to release their babies for adoption. The data show that the extent of risk does not vary with plans for the baby. This finding was different than the Lightman and Schlesinger observation in which those residents who were planning to keep their babies were considered the least likely to become adequate mothers.

The following section describes the ways in which the maternity home residents who intended to keep and raise their babies planned to cope. The indicators used in examining their ability to cope, or lack thereof, were: who they planned to call upon for support (emotional) or help with the baby, where they planned to live and what financial arrangements they intended to make.

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[37] Guyatt, "Children Raising Children".

In terms of future emotional support or assistance with their babies, the majority of residents (57.4%) were planning to call upon their parents. Without doing a follow-up study on these women, there is no way of determining whether they did receive support from their parents. Some of the directors questioned whether support, if provided, would be significant. However, the results of other research endeavours have shown that unmarried mothers received considerable emotional support from their family particularly from their mothers whether living with them or not(38) and that this support was still provided at six, twelve and eighteen months following the babies' birth.(39)

The residents indicated that they hoped to receive child care assistance from relatives other than their parents as well as friends. The London Children's Aid Society study on unmarried mothers who kept their first-born children similarly found that friends were the third most important source of assistance to the unmarried mother.(40)

A relatively small portion of residents (18.0%) expected to obtain assistance from a children's aid society. In contrast, the 1978 data showed that 55% planned to have future contact with agencies, for example the children's aid society. The decreasing and limited use of a children's aid society for post-natal service of late is illustrated in the following table by a comparison between the number of unmarried mothers as reported by Ontario Vital Statistics and the number of unwed mothers receiving service from a children's aid society.(41)

Births to Unwed Mothers and New Unmarried Mother Cases Opened in Children's Aid Societies

| Year | Births to Unwed Mothers | CAS new unmarried mother cases | Percent of Total |
|---|---|---|---|
| 1969 | 9,802 | 9,798 | 99.9 |
| 1974 | 8,286 | 4,313 | 52.1 |
| 1979 | 10,157 | 2,943 | 29.0 |

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[38] Lucille J. Grow, Early Childrearing by Young Mothers (New York: Child Welfare League of America, 1979), p. 114.

[39] Judith Pozsonyi, A Longitudinal Study of Unmarried Mothers Who Kept Their First-Born Children (Ottawa: Department of Health and Welfare, 1973), p. 26.

[40] Ibid., pp. 26-27.

[41] Guyatt, "Children Raising Children."

The putative fathers were not regarded by the residents as a major source of potential support. About 16% of the residents were planning to call upon the putative fathers for assistance or support. It is interesting to note, however, that the findings from other studies show that the majority of unmarried mothers had contact with the putative fathers after the birth. But the frequency of their visits diminished slightly over time.(42) The Lightman/Schlesinger profile of residents planning to keep their babies showed that 57% planned to have future contact with the fathers, 21% did not plan to have contact with them and another 21% were uncertain.

A few of the 1981 residents (8.2%) planned to seek assistance from public health nurses. And, almost 15% stated that they would seek support from "other" sources.

On the basis of future living arrangements of the residents planning to keep their babies, the most frequent response was living on their own (36.1%) followed by living with parents (32.8%). The remaining residents intended to live with other relatives, friends, the putative father, remain in the maternity home in the mothers and baby program or elsewhere. The literature suggests that unmarried women commonly live with their family immediately after birth but after several months they are living with a husband or a boyfriend. In a Milwaukee study conducted by Grow, 44% of the participants lived with their parents one month after delivery, 27% were still living with them at 18 months and a decreased portion - 13% - were still in their parents' home three years after the birth. Conversely, 10% of the women were residing with a boyfriend one month following the birth and 51% had moved in with a boyfriend at 18 months.(43) Among the 1981 maternity home residents, only 8.2% indicated that they planned to live with the putative father. In view of other studies on unwed mothers, one has to wonder whether more of them will be living with the putative fathers than indicated or whether women who seek admission into a maternity home have fewer contacts with the putative fathers than the general population of unwed pregnant women.

In terms of their intended financial arrangements, an overwhelming majority (63.9%) stated that they were going to apply for public assistance. This finding is in agreement with the 1978 data which indicated that 69% of the residents planning to keep their babies were planning to collect Family Benefits. This is confirmed by the increase, over time, of unwed mothers receiving Family Benefits Assistance in Ontario. In 1969 there were 4,122 unwed recipients as compared to 15,627 in 1979.(44) It is thought that most unwed women are in receipt of Family Benefits Assistance for six to nine months. Because some of them do receive assistance for longer periods of up to 10 years, the average period of dependency is two years. However, once they go off of welfare they generally do not go back on it. Most unwed women with young children terminate their public assistance benefits because of marriage, employment or relocation in another province.

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[42] Harriet B. Presser, "Sally's Corner: Coping with Unmarried Motherhood," Journal of Social Issues 36 (1) Winter 1980), pp.112-113.

[43] Grow, op. cit., pp. 30, 74.

[44] Guyatt, "Children Raising Children."

Similar findings are reported by a study in Nova Scotia. It involved a longitudinal study of 346 unmarried mothers of whom half were in receipt of public assistance following the birth of their babies. But, their dependency on this assistance decreased over time. Only one-third were in receipt of welfare 18 months after the birth.(45)

A number (13%) indicated that they hoped to get financial support from their parents. The literature, however, suggests that young mothers' parents provide indirect support (e.g. gifts, child care, clothing) rather than the more direct forms such as cash payments.(46)(47)

Some of the residents (13.1%) planned to support themselves by working. Almost all of these women planned to work part-time.

A small percentage (9.8%) of the residents expected to receive financial assistance from the baby's father. This finding is consistent with that of other research studies which show that unmarried adolescent mothers cannot rely on the fathers of the children to support their children and themselves.(48) A Baltimore study found that only four percent of the unmarried mothers sampled, most of whom were Black, were supported by the child's father at a five year follow-up.(49)

About 3% of the residents stated that they planned to get financial support from other sources. No one expected to obtain this type of support from other relatives or friends.

In summary, the residents who intended to keep their babies planned to cope with child rearing by receiving emotional support and assistance with their babies mainly from their parents as well as from other relatives and friends. The degree of this support may be questionable. These women planned to live primarily on their own or with parents. And, they intended to receive financial support mostly from the government, from parents or through working part-time.

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[45] MacDonnell, loc.cit.

[46] Ontario, Ministry of Community and Social Services, Unmarried Teenagers on Provincial Benefits.

[47] Frank F. Furstenberg, Jr. and Albert G. Crawford, "Family Support: Helping Teenage Mothers to Cope," Family Planning Perspectives 10 (6) (Winter 1978): p. 326.

[48] Presser, loc.cit.

[49] Frank Furstenberg, Jr. Unplanned Parenthood: The Social Consequences of Teenage Childbearing (New York: The Free Press, 1976).

## 5. Summary of Major Findings

### i. The Profile of Maternity Home Residents

a) Demographic Characteristics:

- Residents are younger now than in the past.
- The majority are teenagers between 15 and 19 years of age.
- While the majority (60%) lived in a two-parent family, a substantial portion (40%) lived in a one-parent family.
- Almost two-thirds of the residents were students prior to entering the home.
- Slightly more than half of the residents had worked immediately prior to their pregnancy mostly in part-time service positions.

b) Social Variables:

- Living with parents prior to admission was the most common pattern.
- On one hand, a proportion (1/5 to 1/3) either received visitors or made visits frequently and on the other hand, a similar proportion had not had any visitors and seldom left the home to visit others.
- Parents and friends were seen by the residents as being more accepting and supportive of the pregnancy than the putative fathers.
- The largest source of referrals was self, family and friends.
- More than one in four residents had been a ward of a children's aid society.
- A small proportion had been receiving counselling, mental health services or probation services.

c) Medical and Health Related Factors:

- Three-quarters perceived themselves to be in excellent or good health.
- More than one half saw a doctor during the first trimester of their pregnancy.
- The majority claimed that the pregnancy was their first.
- All the residents had learned about birth control; however, more than three-quarters had not practised any method.

ii High Risk:

- The majority (87%) of the maternity home residents were at risk on at least one factor suggested by the literature and more than one-fifth had elements of risk in a number of different areas of their life.
- The residents were typically at some risk, occasionally at considerable risk but seldom at extreme risk.
- The agency involvement and health subindices were the two major contributors to the overall risk index.

iii Residents Over 21 Years of Age

- The residents 21 years and older as compared to those 18, 19 and 20 years of age were found to be more at risk for work problems, namely unemployment, job instability and lower weekly earnings.
- The residents over 21 years of age had a higher score of risk related to agency involvement.

iv Plans for the Baby:

- Slightly more residents were planning to release their babies for adoption rather than keep and raise their babies themselves.
- The residents' intention to keep and raise their babies or relinquish their babies for adoption did not vary with the following variables: age, education, marital status of persons with whom residents mainly lived and the residents' self-reported condition of health.
- Of the residents who intended to keep their babies, more planned to cope with child rearing by: receiving emotional support and assistance from their parents, other relatives and friends; living on their own or with parents; and receiving financial support mostly from the government or parents.

## V MATERNITY HOME PROGRAMS

This section describes the programs provided by maternity homes in Ontario. The information was obtained from the directors of the homes and from program supervisors of the Ministry during personal interviews. In addition, suggestions pertaining to programs which were made by the residents are summarized. Also included are their comments regarding their satisfaction with these programs.

In order to raise issues respecting service delivery, it is important to reiterate the objectives of the maternity homes which were outlined at the beginning of this paper. In summary, the maternity homes still provide accommodation and emotional support to protect some of the unmarried pregnant women who feel stigmatized by the community and rejected by their families; prepare women for the birth of their babies; facilitate informed decision-making; and, enhance individual and family functioning. Underlying these basic objectives are a set of principles of service delivery, most of which are common to all children's services. They are as follows:

- Other non-residential alternatives should be considered and identified as unavailable, not viable or not preferable.
- A variety of programs should be provided in one setting in order to meet a number of different needs.
- The programs should be the highest quality possible within the existing levels of funding.
- The residents should be informed of the possible courses of action and involved in the decision making process, if feasible.
- The effectiveness and efficiency of service delivery should be regularly evaluated.

The report on the programs are organized under the following six categories: Medical/Health, Life Skills, Counselling, Parenting, Aftercare and Education. For specific details on each home see Appendix 3. It is important to point out that the maternity homes work in cooperation with their community to provide their programs. They rely heavily on professionals seconded from other local organizations (e.g. public health units, children's aid societies and boards of education) as well as on volunteers and students.

### 1. Medical/Health

Medical and health programs are provided in order to prevent and treat any maternity-related illnesses which may pose health risks to either the unmarried mothers or their babies. This suggests that pregnant women in maternity homes may be better prepared for the delivery of their babies than pregnant adolescent women in the general population. This is based on the findings from the literature which indicate that pregnant adolescents commonly do not obtain pre-natal care.(50)(51)

Some of the homes have an in-house physician who sees the residents on a regular basis. Other homes which do not have an in-house doctor ensure that the residents are examined by a doctor at a community clinic or by their own private physician, if feasible. In addition, the homes have a close connection with a major hospital in their community to which residents are referred when more extensive medical care is required.

In addition to ensuring that the residents receive regular medical care, all the homes offer a pre-natal program. This program is conducted in collaboration with a qualified nurse. The sessions include instruction on nutrition, labour and delivery and participation in an exercise and breathing program. The women are also given information on human physiology and birth control. This information is offered to improve the residents' self image and to reduce the likelihood of further unplanned pregnancies.

### 2. Life Skills

The life skills program is aimed at preparing women to live responsibly and independently. By being part of a group living experience, the residents learn to share some of the basic household tasks, among which are meal preparation, cleaning and shopping. This experience is beneficial and important, particularly to those residents who have never been responsible for or assisted in maintaining a household. Besides this practical and informal experience, the homes provide formal sessions on household management such as budgeting.

In addition to this aspect of life skills training, the homes provide opportunities for assertiveness training and self-growth. These skills are taught to prepare the residents for the future handling of difficulties associated with living on their own.

Together, the individual and household skills training are an effort to enhance the future functioning of these women.

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[50] Billung-Meyer, loc.cit.

[51] McCreary Juhasz, loc.cit.

## 3. Counselling

The homes provide three different types of counselling which together form an integrated program. They are formal counselling (i.e., casework), formal information sessions and informal counselling. Each type is briefly discussed below.

The formal counselling or casework focuses on the identification and resolution of problems which may exist in addition to the pregnancy. These are problems that relate to individual dysfunctioning or relationships with others (e.g. family) and may relate to the underlying causes of the pregnancy.

The sessions are typically provided on a one-to-one basis between a worker and a resident. Some of the homes have made attempts to involve the resident's family in these sessions. In fact, one of the homes engages the parents and boyfriend in counselling sessions as a routine practice. Presumably, the involvement of significant others in problem solving is beneficial. For example, the residents would be less likely to deal with their pregnancy, the underlying causes of their pregnancy and make their decision regarding the baby in isolation. Also, involving the family and boyfriend may predispose them towards providing future support and financial assistance.

In addition, some of the homes provide counselling sessions on a group basis. These sessions provide an opportunity for the residents to share their problems (e.g., stresses associated with pregnancy) and help each other to deal with them.

The formal information sessions are also provided on an individual and a group basis and are intended to assist the residents in making as realistic as possible decisions for themselves and their babies. The residents are given information on parenting and on the adoption process.

In addition to these formal counselling and information sessions, there are also informal ways in which the residents receive assistance in dealing with their pregnancy and other problems. For example, the group living experience within the maternity home facilitates sharing and resolving concerns among residents and between residents and houseparents or nurses.

A concern that was identified from this review is that some residents may not receive sufficient formal counselling. Some homes may not have adequate staffing, due to financial constraints, to provide in-depth one-to-one counselling to all residents who want and need it. Consequently, these homes encourage and rely on a children's aid society worker, who has been assigned as a liaison worker to the home, to assist with or assume the full responsibility for counselling. However, according to some maternity home directors, some children's aid workers, because of high workloads, have minimal contact with the residents and their families, except in cases where the residents are wards.

In other cases, where a resident has already established an ongoing relationship with a children's aid society worker prior to her admission, that worker or the resident may feel that maintaining this relationship is a priority and consequently, a referral may not be made to a local liaison worker. A problem that became evident was that some residents who had prior involvement and were from out-of-town either saw or heard from their worker infrequently while in the home.

It seems then, that there are some residents who may not receive sufficient formal counselling. In order to assess the seriousness of this concern, it is important to look at the needs of the individual and the informal counselling opportunities in the home and to determine whether or not they are an effective alternative.

### 4. Parenting

Many of the homes have initiated a program on child care and positive parenting techniques. This was done in response to two major factors: the increasing number of residents choosing to keep their babies, and the concern of maternity home staff regarding the parenting ability of single adolescent mothers and their potential for child abuse or neglect. This program is coordinated by maternity home staff using in many cases a range of seconded professionals (e.g. teachers, pubic health nurses).

The parenting program is geared to those residents who plan to keep and raise their babies. In some homes, a child care component is included in the aftercare program and is restricted to post-natal residents i.e., those women who remain in the home following the birth of their babies and who have decided to keep their babies. Other homes have developed a separate program, which is optional in some homes and compulsory in other homes. In those homes where this program is optional, there is the concern that if those residents who did not participate in this program decided to keep their babies, they may be less prepared to deal with their new role as mother.

One of the homes runs an infant care program which is designed to provide theoretical knowledge and practical experience regarding child development, management, nutrition and infant stimulation. The practical experience includes a practicuum in the home's infant care centre. By being compulsory for all residents regardless of their plans for their babies, the program assists all women in making an informed decision about themselves and their babies, in promoting a better understanding of the growth and development of children, and in encouraging a healthy relationship with their children, if they choose to keep their babies.

Given the increase in recent years in the number of residents keeping and raising their babies, it seems reasonable that all maternity homes should develop a practical child care program. With society's continued concern about the teenaged mother's ability to parent effectively, the opportunity to ensure that at least this population of unwed pregnant women receives as complete as possible parenting education should not be missed.

## 5. Aftercare

Many of the homes have expanded their service, on a limited basis, to women beyond their period of confinement. Length of stay in this residential program varies with the policy of the individual home and with the needs of the resident ranging from a week to three months.

In some homes, the program is designed for women without their babies. The women may remain in or be admitted to the home following the birth of their babies. These may be women who have released their babies for adoption but require post-natal support and counselling to deal with the resultant feelings of separation. Or they may be women who have delivered premature babies and use the time while their babies are hospitalized to re-establish themselves in the community. Or they may be women whose children are temporarily placed in the care of a children's aid society while they are finalizing their future plans.

In other homes, the women with their babies return or are admitted to the home. These women are assisted with their new role as mother. For example, they receive help in learning child care skills, obtaining public assistance and arranging for housing. This program may have the extra benefit of assisting the pre-natal residents in making a more realistic decision regarding their babies by exposing them to some of the realities of motherhood.

The aftercare program seems to be an effective way of helping residents during the period following the birth. They are assisted with unresolved problems regarding the pregnancy, taught child care skills and are given additional time to organize for housing, employment and possibly day care.

However, the directors who operate mothers and baby programs expressed concern about residential post-natal care. They noted the following:

- In a maternity home setting, the women may not experience some of the realities of raising a child and consequently, may end up keeping their babies — a decision which may not be the most appropriate one.

- The aftercare program may prolong dependency by delaying decision-making regarding housing, employment, etc.

- A length of stay of two to three months in the aftercare program is so short that it may not be significant in adequately preparing all women for their new role, particularly for those women who were not in the home during the pre-natal period.

- The mother and baby program may glorify motherhood to the extent that it influences the pre-natal residents to keep their babies who might have otherwise relinquished their babies for adoption.

Further evaluation research would be useful to assess the validity of these concerns and how the programs might best be modified to minimize any substantiated effects.

## 6. Education

The educational component has been part of the maternity home program for many decades. Initially, this program was run by volunteer teachers. By the 1960s, the local boards of education assumed responsibility for the provision of school instruction. However, only since the 1970s has the education program become better developed and a major aspect of the maternity home overall program. The emphasis on education is in response to a number of factors:

- An increasing number of younger women seeking maternity home service, many of whom were attending school when they became pregnant.
- The recognition that adolescents typically drop out of school when they become pregnant and once they leave the school system they seldom return.
- The increased awareness that some school-aged women quit school before they become pregnant suggesting that the pregnancy is a symptom and not necessarily the cause of school drop out.
- The growing number of adolescent pregnant women choosing to keep and raise children on their own and therefore, requiring additional skills for independent and family functioning.

In most cases, the homes have contracted with the local school board (under section 28 of The Education Act) for the secondment of one or several teachers. The teachers provide academic instruction and vocational training up to five days per week using either the classroom or tutorial model of teaching. A number of the homes have made their school program available to non-residents as well as residents. Schooling is generally compulsory for residents less than 16 years of age and is strongly encouraged for residents older than 16 years especially if they are not employed.

The provision of education has a number of obvious benefits for residents and non-residents who are admitted to the program. For example, it provides an opportunity for them to continue and possibly complete their level of education in a comfortable environment. This opportunity to further their education increases their chances of obtaining a job. The education program also teaches the residents (and non-residents) some very practical job-related skills such as typing. This may enhance their opportunity for acquiring somewhat more secure and higher paid work. In addition, the low teacher/student ratio enjoyed in homes allows for more intensive instruction. This may be beneficial to the residents and non-residents, a number of whom, according to the directors, have had difficulty in functioning in the traditional school setting. The individualized education program also provides women with emotional support. By being exposed to this model of education, residents (and non-residents) may be encouraged to continue their education.

The range of content of accredited subjects available to the residents, however, needs to be expanded. Recently, the Ministry of Education has prepared a draft set of guidelines for the development of a curriculum on life skills/management. A number of the units of study proposed for this course (e.g. parenting, human relations, nutrition and career planning) would be useful for maternity home residents. This broader range of subjects would provide them with information that is helpful for setting up their own household and raising a child.

## 7. Summary of Responses from Residents

The residents were asked whether the maternity homes should provide any other programs. Their responses are shown in the following table. This table also includes the number of residents who made the particular suggestion and the number of homes represented by these residents. The implications of the data are limited by the fact that it is unclear whether or not the homes already provide the program which is suggested by the residents.

RESIDENTS' SUGGESTIONS REGARDING PROGRAMS

| Suggestions | Number of Residents who made suggestions | Number of Homes represented by Residents who made suggestions |
|---|---|---|
| 1. Medical/Health: | | |
| • Need for additional pre-natal care | 3 | 1 |
| • need for more exercise | 5 | 4 |
| 2. Life Skills: | | |
| a) Household: | | |
| • more practice in cooking | 5 | 5 |
| b) Recreational: | | |
| • more emphasis on recreational activities, crafts, physical fitness | 18 | 9 |
| • more activities for those not taking courses | 4 | 2 |
| c) Other: | | |
| • more assistance with budgeting | 2 | 2 |
| • more instruction on first aid | 2 | 2 |
| • more information on legal rights | 5 | 3 |
| • more assistance in seeking jobs | 1 | 1 |
| 3. Counselling: | | |
| • additional counselling | 3 | 3 |

| Suggestions | Number of Residents who made suggestions | Number of Homes represented by Residents who made suggestions |
|---|---|---|
| 4. **Parenting:** | | |
| • more knowledge and/or practical experience in child care (changing diapers, making formulas, cutting toenails, soothing an upset infant) | 14 | 6 |
| 5. **Aftercare:** | | |
| • need for an aftercare program (e.g., nursery, day care) | 5 | 3* |
| 6. **Education:** | | |
| • more emphasis on education | 1 | 1 |
| • more variation in school courses | 1 | 1 |

*One of the three homes does not have an aftercare program; one home has a program for mothers only; one home has a mother and baby program.

It is clear from these responses that the residents want more recreational activities. In fact, 18 residents in nine homes indicated that more emphasis ought to be placed on recreational, crafts and physical fitness activities. It is interesting to note, however, that some directors claim that residents are reluctant to participate in planned recreational activities. It is worth noting that only five of the directors of the nine homes stated that a recreational program was provided. It seems then that this is one area which may require further program development. However, the homes have tended to rely on volunteers to run this program and without additional staffing, program expansion may not be feasible.

Several residents also expressed a need for more knowledge and practical experience in child care (e.g., changing diapers, making formulas and soothing an upset infant). This suggestion was made by 14 residents in six different homes, five of which do offer sessions on parenting. The need for more information on child care and management has been noted in other research studies on single mothers. For example, the Halifax study on unmarried mothers who kept their children found that the children of unmarried mothers had experienced more hospital emergency treatments during their first 18 months of life than the children of married mothers. These incidents resulted from a lack of child care knowledge and a lack of confidence on the part of the mother. In a number of cases, the children were not seriously ill. In fact, almost half of the emergency contacts were found to have stemmed from causes other then true emergency problems. According to the community health nurses, these cases could have been dealt with in the home had the mother been more confident with the child or more knowledgeable in general child care.(52) This finding supports the residents' suggestion for increased programming in child care and development.

The other suggestions were made by relatively few residents who were residing in a few homes. These isolated comments, however, limit the usefulness of the other suggestions.

The residents also were asked if the home (i.e., programs) was meeting their expectations. Almost four-fifths (79.5%) felt that the home had met their expectations or was better than they had originally anticipated. This suggests that there is a high level of satisfaction among maternity home residents. A small group (14.9%) reported that the home was not meeting their expectations. The remainder (5.7%) did not respond. The following table summarizes some of the typical responses made by the residents:

### RESIDENTS' COMMENTS REGARDING THE MATERNITY HOME

| Comments | Number of Residents who made suggestions | Number of Homes represented by residents who made suggestions |
|---|---|---|
| Home was better than originally expected because (N=61): | | |
| • it was not as restrictive | 26 | 11 |
| • it offered a full range of programs | 13 | 6 |
| • staff and residents were warm and friendly | 24 | 11 |
| • it allowed for individual privacy | 3 | 1 |
| Home was not as good as originally expected because (N=21): | | |
| • it was too restrictive | 13 | 5 |
| • it lacked sufficient activities | 5 | 3 |
| • staff and residents were unfriendly and impersonal | 7 | 6 |
| • poor or inadequate supply of food | 8 | 5 |
| • diversified program | 3 | 1 |
| • it did not provide a weekly allowance | 4 | 2 |
| • it required an additional telephone | 1 | 1 |

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[52] McDonnell op.cit., pp. 232-233.

Those residents who were pleased with the maternity home commented that the home was not as restrictive as they had perceived it to be. In fact, some had originally thought that the home would be like a jail, an army camp, a group home for juvenile delinquents or a convent. Others enjoyed the freedom, for example, to visit family and friends and to make their own decision regarding the baby. They were not aware that the home offered a full range of programs such as education. Nor had they realized that the staff and other residents would be so friendly, warm and concerned. A number appreciated that private rooms were provided which they saw as showing respect for their privacy.

On the other hand, some residents were disappointed with the home. They felt that staff were strict and uncaring, the in-house doctor was impersonal and that the other residents were unfriendly. Some indicated that there were not enough activities. This comment was made by residents who were not attending a school program. A number felt that the home did not provide them with enough freedom to go out on their own, to watch television or to sleep. Some complained about the poor or inadequate supply of food. A few residents suggested that the home should provide them with an allowance which could be used for telephone calls, public transportation or entertainment.

In addition, some residents expressed concern about living in a home that served non-pregnant disturbed adolescents as well as pregnant women. In particular, they reported that they had not been informed of the dual programming prior to admission. Furthermore, they indicated that they did not have a good rapport with the non-pregnant residents and at times were even fearful of them. And, they felt that their association with these other residents implied that they, too, were deviant.

The fact that several residents were not aware that their home offered a full range of programs such as education, and that a few respondents did not know prior to their admission that the home had a diversified program accepting non-pregnant adolescents as well as pregnant women, may be because of the following reasons:

- A number of applicants live in areas which are far from that of the maternity home. This may mean that a pre-admission interview may not always be possible and consequently, the applicant may not be adequately informed of the maternity home programs.
- Some residents may feel ambivalent about entering a maternity home and consequently, may not listen to all the details about the home told to them by their referral source and/or the director during the pre-admission interview.
- Some referral sources may infrequently refer women to a maternity home and as a result, may not be aware of the current programs offered by a home.
- The proliferation of certain organizations (e.g. Birthright) in recent years may have made it difficult for them to keep their new volunteers and staff abreast of all the programs offered by maternity homes.

Despite these reasons, a clear inference can be made that maternity homes need to work on providing more information about themselves to potential residents and referral sources.

In order to better understand why the programs were or were not meeting the residents' expectations, the data on their expectations of the home were examined in relationship to the sources of referral. While the residents were asked "is this home meeting your expectations?", it is unclear from the analysis whether the responses relate to expectations or to satisfaction of programs. Despite this ambiguity, the findings are reported here because of the variation in responses among the residents. The following table illustrates this relationship.

Residents' Expectations of the Maternity Home
by Sources of Referral (1981)

| Referral Sources | Maternity Home Met Residents Expectations (%) | Maternity Home did Not Meet Residents' Expectations: | |
|---|---|---|---|
| | | Better than Expect. (%) | Worse than Expect. (%) |
| Nurse/Doctor (N=18) | 55.6 | 27.8 | 16.7 |
| Other (N=30) | 50.0 | 23.3 | 16.7 |
| Social Service Agency (N=24) | 45.8 | 37.5 | 4.2 |
| Clergy (N=13) | 30.8 | 38.5 | 23.1 |
| Children's Aid Society (N=30) | 26.7 | 56.7 | 16.7 |
| Friends (N=23) | 26.1 | 56.5 | 13.0 |
| Self/Family (N=28) | 17.9 | 60.7 | 17.9 |

NOTE: Percentages do not add up to 100% because other categories (i.e., Missing and No Information) were excluded. The referrals from Probation and Aftercare were excluded from the table since N=1.

One observation from the above table is that of the residents who were referred by the two most prevalent referral sources (a children's aid society or themselves), a larger proportion felt that the home had not met their expectations. Most of them felt that it was better than originally anticipated. This finding supports the need for maternity homes to provide more information about themselves to applicants and referral sources. However, this finding is anomalous to the opinion of some directors, who noted that the residents who refer themselves are better informed about the maternity home because they have heard about it from former residents.

If the table is seen as an expression of satisfaction, it is noteworthy that in all cases the majority of the residents were satisfied (i.e. the home met their expectations or it was better than expected) rather than disappointed with their experience.

In summary, this section has described the programs offered by maternity homes and raised a couple of issues regarding the programs provided. This section has also summarized the residents' suggestions for change in programs and noted their level of satisfaction. The following summarizes the suggestions. While these suggestions are useful in terms of planning and implementing programs to meet a broad range of residents' needs, program development may be limited, however, by the funding available.

### 8. Implications for Consideration:

There appears to be a need for maternity homes to do the following:

- where residents do not receive formal counselling, to determine whether their needs are such that other counselling arrangements should be made;
- to find ways of providing more practical knowledge and experience in child care;
- to evaluate the existing residential aftercare program to determine the extent to which it influences pregnant women and mothers to keep their babies, prolongs dependency by delaying decision-making and whether and to what extent it can adequately prepare women for motherhood in two to three months;
- to expand the recreational program;
- to provide more information about their programs and facilities to potential residents and referral sources so that residents are more prepared for their stay in the home.

## VI ISSUES

The maternity homes have witnessed changes in recent years in the characteristics of their clientele. For example, the residents are younger now than in the past and according to the directors, they have experienced more emotional problems than previous residents. This change in resident characteristics is reflected in maternity home programs such as education and counselling. The homes have also noticed the change in the decisions made by residents regarding plans for the baby. An increasing number are choosing to keep and raise their children rather than to place their babies for adoption. In order to assist the women in making an informed decision and to prepare them for parenthood, the homes have introduced parenting and aftercare programs.

Maternity homes are involved in a continuing effort to meet the needs of their client population. Through the Association of Maternity Homes, it has been possible for the homes collectively to share experiences and trends, develop joint endeavours and promote a more consistent service across the province. However, a number of issues were identified during this survey. They are raised in this paper for the purposes of initiating discussion among maternity homes and/or between maternity homes and the Ministry and generating policy and program decisions. These issues relate to the role of maternity homes, the public awareness of maternity home services, program complexities, the financial situation and comprehensive research. A brief discussion of each of the issues follows.

### 1. The Role of Maternity Homes

Issue:

- the role of maternity homes in serving unmarried pregnant women and unmarried mothers

Background:

Maternity homes were established as a societal response to illegitimacy and have assumed for many years a major role in dealing with unwed pregnancy. However, with the change in society's attitude toward a greater acceptance of unwed pregnancy and motherhood and with the increased knowledge of the consequences of unwed pregnancy and motherhood, other programs and services evolved to also serve the needs of this population. Some writers, for example Miller (1973), even went so far as to conclude that maternity homes had lost their purpose and faced extinction.(53) While a few of the homes in Canada and the United States shut down in the 1970s, the majority have continued to provide a service to unmarried mothers.

In order to evaluate the role of maternity homes currently and in the near future, it is important to place maternity homes into a larger service perspective. The following table lists for illustrative purposes a variety of needs of these women and provides examples of community programs aimed at meeting these needs. It is important to point out that these programs have been designed for all pregnant women and/or mothers and not primarily for unmarried pregnant women and unmarried mothers.

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[53] Samuel O. Miller, "Maternity Homes: The Case of a Dying Institution," Journal of Sociology and Social Welfare 1, (Fall 1973): 79-83.

## Programs and Services In the Community for Pregnant Women and Mothers

| Need | Programs |
|---|---|
| medical/health | pre-natal programs provided by physicians, nurses and public health units include pregnancy monitoring, nutritional counselling, instruction in breathing and exercise. |
| information on contraception, conception, abortion, adoption and parenting | may be provided by public health units or planned parenthood associations or pro-life organizations or boards of education or children's aid societies. |
| counselling on informed decision-making, adoption, parenting and personal and family problems | may be provided by children's aid societies. |
| educational | continued educational opportunities available in the regular classroom or through home instruction, correspondence courses and a few alternative education programs for pregnant teenagers (e.g. Montrose - Toronto, Y - Windsor). |
| financial | financial assistance may be available by municipal and provincial governments (e.g. General Welfare Assistance, Family Benefits and Unemployment Insurance for those who worked). |
| housing | subsidized housing may be available under the Ontario Housing Corporation. |
| child care relief | infant day care and emergency infant care and support may be provided by local organizations (e.g. Teen Family Program in Thunder Bay offers emergency infant care and support.) |
| parenting information | self-help groups for the following target groups: single parents, teenage mothers at risk for parenting problems and single parents whose children are at-risk for developmental problems. These may be provided by, for example, a local Y, infant stimulation programs or a children's aid society. |
| employment counselling and vocational training programs | provided by Canada Manpower and by the Ministry of Community and Social Services for mothers in receipt of social assistance. |

The listed programs are, by and large, provided separately by different specialized organizations as opposed to being provided by one organization under one roof. This means that a woman with a variety of needs has to approach a number of organizations to have her needs met. This can be complicated by the reality that the services are not uniformly available throughout the provinces. While most are found in major urban centres, even here, they may be located in different areas within the centre so that considerable travelling and scheduling may become a necessary prerequisite for service. A number of the programs, particularly those which are group oriented, are geared for married pregnant women (e.g. pre-natal classes) or non-pregnant women (e.g. the regular school program). Unmarried pregnant women may perceive that they will be stigmatized by these other persons and consequently, may choose not to avail themselves of the community services. Some of the programs (e.g. public assistance and housing) may not be accessible to all age groups, particularly the very young women. Because of such gaps in service, some women may not be able to receive service and consequently, their needs may not be met.

It is worth noting that the children's aid societies may provide a broad range of programs (eg. information, counselling and parenting) since their legislative mandate is "to assist the parents of children born or likely to be born outside of marriage and their children born outside of marriage."(54) Although they have the legal mandate to provide service to this target population, the extent to which services are given depends on the program and funding priorities of a local society and the willingness of unmarried parents to ask for these services from a society. In fact, the children's aid society caseload statistics, as previously noted, show that fewer unmarried mothers in recent years are seeking service because of their fear of the societies as "baby-snatching organizations".

It is within the context of the other programs, most of which are non-residential and have a specialized focus, that maternity homes can be seen as having a unique and important role. Their service delivery is based upon the coordinated efforts of a number of local organizations, professionals, volunteers and students. Because the homes are a voluntary residential service without the public image associated with children's aid society services, they can assess and begin to meet the needs of unwed pregnant women during the pregnancy and following the delivery. They offer a more holistic approach than most toward dealing with the needs of unwed pregnant women. Each home, to some extent, has a number of programs which are intended to cover a wide range of needs. As they are now set up, they can increase the likelihood of good pre-natal care; improve access to information about parenting, conception, contraception, etc.; provide individualistic and supportive educational experiences; encourage the development of parenting skills; provide assistance in coping with the pregnancy; encourage the development of supportive relationships among the women; and initiate counselling that could, over time, help the women face some of their problems.

Maternity homes can also identify and initiate the supports needed after delivery. For example, the mother and baby programs have been developed in some homes to assist women in their role transition.

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[54] Ontario, The Child Welfare Act, Sec. 6, Subsec. 2 (g).

Maternity homes clearly have an important place in the service system; however, their resources and availability in only a few urban centres limit their service delivery role. Their role in the near future needs to be assessed, particularly in relation to the proposed initiatives of the Ministry of Health which include counselling, referral and follow-up for women identified at risk. It is suggested that, at the local level, representatives of maternity homes, the Ministry, children's aid societies, public health departments and other relevant service providers, many of whom already work closely with the maternity homes, should initiate a joint planning process to address general service issues such as gaps and overlaps. In particular, some discussion might revolve around the following specific issues: one, whether maternity homes ought to provide a post-natal program or whether other community services should assume this responsibility; and two, whether maternity homes should further extend their current service delivery model (i.e. utilizing staff seconded from other community organizations) on a non-residential basis. This planning process would provide the basis for policy and program decisions regarding the services for unwed pregnant women and unmarried mothers, in general and regarding the role of maternity homes, in particular.

## 2. The public awareness of maternity homes

Issues:

- the extent to which applicants are aware of the programs of maternity homes
- the extent to which there are other pregnant single women who are in need of service and could benefit from a maternity home but who are not aware of the programs provided by maternity homes

Background:

The maternity homes traditionally were viewed as confidential refuges, places where women could escape from social gossip and condemnation. The home helped prepare these women for the birth of their babies, for the future separation from their babies and for their return to the community. With the acceptance of clientele who were younger and were planning to keep their babies, the homes modified and expanded their programs. The homes are now settings where women can prepare for parenthood, where women can learn homemaking and other life-skills and where women can further their education. The extent to which referrals (or referring agencies) are aware of the changes in philosophy of maternity homes as reflected in the programming is a question that needs to be considered by maternity homes.

The statistics on referral sources indicate that the number of women who are referring themselves to maternity homes has been increasing in recent years. These are women who, according to some directors, have heard about the maternity home experience from former residents and consequently, are well-informed about the maternity homes. It is suggested that some of them even select a particular home on the basis of its programs.

However, the data from this survey also indicates that there are some residents who, when they were accepted into the home, were not aware of the full range of programs such as education, or were not aware that the home had a diversified program, accepting non-pregnant adolescents as well. Given that some residents are uninformed about the maternity home, the homes should take a look at why the residents have this poor understanding and find ways of informing as fully as possible both the referral sources and the residents of their programs, facilities and purposes.

On the assumption that some residents (and possibly some referral sources) are not aware of life in a maternity home, it is unclear how many other unmarried pregnant women who, because they are uninformed of the maternity home programming, do not apply to a home. Consequently, it is not possible to assess to what extent maternity homes are reaching women who are in need of service and who could benefit from being in a maternity home or from obtaining service on a non-residential basis.

The increased visibility suggests that referrals would be appropriately made and that the number of needy women seeking admission would likely increase. This, however, may have implications for the available resources. Thus maternity homes, by becoming more visible, have to be prepared to deal with issues arising from this fact.

### 3. Program Complexities

Issue:

- the extent to which maternity homes effectively serve the different groups of residents

Background

There are day-to-day program realities which also present important issues for consideration. These derive primarily from the diversity of the client population and the ambitious intentions of maternity homes to meet a wide range of needs of their residents.

At a time when most residents basically looked only for a confidential refuge and the majority gave up their children for adoption, programming complexity was minimized. However, these simple days are now a thing of the past. With approximately half of the residents planning to keep their babies and half planning to relinquish their babies, complexities are introduced into maternity home programming. Those who are planning to keep their babies need assistance in preparing themselves for motherhood (e.g., information on child development and management), whereas those who are planning to release their babies for adoption need assistance in dealing with resultant feelings of guilt and separation. This dual population, each with their own needs, is placing competing demands on the homes. A number of questions arise, as follows:

- Can maternity homes, while focusing their service heavily on the new parent, still meet the needs of those who plan to place their babies for adoption and those who are undecided and/or change their mind?
- Should maternity homes focus on the time during the pregnancy to meet the general and parenting education needs, health needs and counselling needs of the women, assuming minimal responsibility for the post-pregnancy phase?
- Based on the lack of supports in the community for post-natal care, should maternity homes increase their allocations to aftercare programs such as mother and baby programs?

The residents also differ on the basis of age. Most of them are adolescents, 16 to 18 years of age; however, a portion of the client population (12% to 14%) are adults, over 21 years. Although a small number of older residents are served, the homes have geared their programs to the younger women. For example, the focus of the day-to-day activities is on continuing education. The provision of maternity home service to various age groupings leads to a couple of questions, raised below:

- To what extent does the emphasis on meeting the needs of younger women reduce the possibility of providing other programs which would more fully meet the needs of older women?
- How can maternity homes provide more diversified programming in order to meet the needs of both age groups within the existing staffing and funding levels?

Clearly maternity homes do not serve a homogeneous group of women. While the homes have always served different groups of women, diversity has become more of an issue of late, when the homes began to modify and expand their programs. There is little literature to provide guidance on how to resolve programming and staffing issues which are related to such diverse populations. Consequently, there is value in trying different approaches and in sharing results. Ideally, research or program evaluation efforts should be undertaken to identify which groups of women are being served most appropriately, whether groups of women are not benefitting as much from the maternity home programs and what programs maternity homes should be providing. However, in the absence of the ideal, the testing of experience in planned ways over time can contribute to advances in resolving this issue.

## 4. The Financial Situation

Issue:

- the extent to which maternity home directors plan and implement programs which effectively serve residents and meet Ministry and/or community expectations with fixed funds

Background:

The maternity homes have been experiencing financial difficulties for some time. The Operational Review: Children's and Youths Institutions (May 1979) recommended that the homes be transferred from The Charitable Institutions Act to The Children's Institutions Act in order to allow for more flexible funding in terms of the proportion subsidized by the province and to grant the homes an increase in the per diem ceiling of $17.50.

This transfer to The Children's Institutions Act (April 1980) was a positive step in dealing with financial problems faced by maternity homes. The homes received a series of increments in their per diem ceilings. In addition, this transfer made it possible for the homes to increase their staff complement, for example by hiring professional social workers. And the flexibility of the new funding formula enabled maternity homes to initiate major program changes such as the development of non-residential programming.

According to the funding formula under The Children's Institutions Act, the province subsidizes the portion of the homes' budget not covered by revenue from full and part payments and from charitable contributions. The amount of this public support varies among the homes, ranging from about 60% to 80%. The objective of this funding approach, from the province's point of view, was to encourage the setting of realistic and hopefully dependable full pay revenue targets. This source of revenue is received primarily from children's aid societies and seldom from other sources such as probation and aftercare. The problem, however, is that the full pay money is generally unpredictable and in fact has been decreasing in the last few years for some homes.

The reduction in full pay revenue, from the Ministry's perspective, can be attributed to three developments. One relates to the fact that children's aid societies are now being encouraged according to their new funding formula to reduce their residential expenditures. Accordingly, a child is placed in an outside resource only when absolutely necessary. Reportedly, some societies are referring women to maternity homes without making them wards knowing that they will be supervised and cared for whether or not they are wards. In this way, the societies make a responsible plan for the women without having to pay for their stay in the home. In turn, the homes are expected to admit these women and absorb the financial costs of providing service to them.

The second development arises because the societies are being persuaded, if an outside placement is necessary for their wards, to choose the lowest cost resources available. Consequently, they may seek out alternatives such as foster care in which per diems are significantly lower than maternity homes. The full pay revenue is thereby diverted away from maternity homes.

The third development relates to a basic principle of service delivery, namely, that the number of moves to and from an outside placement should be kept to a minimum in order to allow for continuity of care. Thus young women who are wards of a society and placed in outside care before they become pregnant are encouraged to remain in that setting rather than be transferred to a maternity home. Consequently, fewer wards are being referred to the homes and less full pay revenue is received.

The amount of revenue from part payments is also not increasing. These funds are based on contributions from the residents, their families or other persons on the residents' behalf. An amount is suggested at intake which is calculated on the basis of the individual home's per diem. (See Appendix 3 for the amounts suggested by each home.) A limited amount of money is collected from residents or other persons. Based on the information from the residents in the 1981 maternity home survey, 8.5% of the residents planned to or had contributed to the home and 31.2% of the residents indicated that their parents or the putative father were intending to or had contributed. This finding does not provide information on the amount nor the frequency of the contribution. Furthermore, intentions are not a good measure of the actual payments.

Despite the efforts by the directors to encourage the residents to contribute, it is clear that the portion of this revenue is small and unlikely to increase in itself. Many of the residents are students and cannot afford to contribute. Those who are not students have unstable employment histories reflected by unemployment, low paid positions, part-time employment and high job mobility. A number of residents, according to the directors, cannot rely on their parents to contribute money.

However, it seems that there are a number of parents who should be contributing to the home if they are not already doing so. These are parents of residents who were students prior to admission into the home and consequently, were in receipt of Family Allowance and entitled to receive a Child Tax Credit. They continue to be eligible for these benefits as long as their child remains a student even though their child is admitted into a home and they no longer provide basic care to them. It does seem reasonable for the parents to forward the amount of the Family Allowance to the home to cover the basic costs of care of their children. The practice of parental contributions for residential care has been adopted as a Ministry policy and has been in force in most children's residential services. This practice should be applied to children receiving residential care in maternity homes as well.

The possibility of maintaining, let alone increasing, charitable fund raising has diminished. Inflation, reducing contributions for charity and rising costs of other services operated by approved charitable corporations have put limits on their ability to increase financial contributions.

As a result of the unstable and in some cases declining full pay revenue, the minimal level of financial support from residents and others on their behalf, and the decreases in charitable contributions the homes are becoming more dependent on government support. But the Ministry has not been able, due to the constraints placed upon it, to substantially increase its allocation. As a result, program planning and implementation has been limited.

For example, the homes had expected to expand their service to non-residents in keeping with the recommendation from the Operational Review. Many of the homes now offer child care and life skills, continued educational opportunities and prenatal instruction on a non-residential basis utilizing seconded staff from local organizations, volunteers and college or university students on field placement. No special funding, however, was provided to cover the costs (e.g. food and supplies) for non-residents. The continuance or expansion of non-residential programming should be looked at within the context of Ministry priorities in the area of prevention.

In addition, some of the homes have instituted parenting programs in order to assist the residents in making an informed decision and in preparing them for parenting. These programs depend largely on the cooperation and services of professionals and lay persons in the community. However, if over the longer term these persons or the organizations which employ them, request reimbursement for their services, then that issue will require resolution or the programs may be in jeopardy.

Clearly, the homes are faced with the dilemma of how to provide an effective program in order to meet the needs of their clientele and to meet the expectations from the Ministry and/or community within the current level of funding. The suggestion to require the parents, where appropriate, to forward the amount of the Family Allowance to the homes is unlikely to resolve the financial difficulties of maternity homes. No specific answers or solutions are readily identifiable, though it is clear that programs as well as staffing issues compounded by the financial constraints will require joint consideration and action by the maternity homes and the Ministry area offices.

### 5. Comprehensive Research

Issue:

- to determine the need for more comprehensive research from which to make sound program and policy decisions regarding maternity homes

Background:

The Ministry conducted this review of maternity homes, in part, to examine the extent to which maternity home residents are vulnerable or at risk. This information was gathered to assist the homes in assessing the appropriateness of their programs and in considering the viability of alternate programs as the basis for the development and review of their service plans.

The survey has provided some descriptive data on the residents in maternity homes, suggesting the following:

- Maternity homes are reaching younger pregnant women, about whom there is general concern, at a time when they represent a decreasing proportion of the unwed pregnant population.

- Maternity homes are reaching a group of unmarried pregnant women over 21 years of age who are at considerable risk.

- Maternity home residents as a group are typically at some risk, occasionally at considerable risk but rarely at extreme risk.

However, the usefulness of these findings is limited because the study provides only a one point-in-time picture of the residents, relies solely on self-reported data and excludes some key questions relating to risk. Importantly, the study does not include a comparison/control group from which to make conclusions about maternity home residents. Unless the characteristics of the unwed pregnant population in general are known, it is not possible to evaluate the appropriateness of the clients maternity homes currently attract nor it is possible to assess whether or not maternity homes are drawing women at greatest risk. For example, by not knowing how many pregnant single women in the general population were or had been a ward of a children's aid society, it is not possible to conclude whether the ratio of one in four maternity home residents who were or had been wards is high. Comparative data on the general population would assist in making some conclusions respecting the level of risk of maternity home residents and would provide information from which to make policy and program decisions relating to maternity homes.

The survey indicated that an increasing number of residents intended to keep their babies rather than release their babies for adoption. Despite this trend, only about 50% overall actually choose to keep their babies as compared to approximately 90% of the unwed pregnant adolescents in the general community who keep their babies.(55) A better understanding is needed of why maternity home rates of keeping babies is lower than that in the society at large. Some key questions to aid in understanding this phenomenon are as follows:

- To what extent are maternity homes attracting pregnant women who have a preference toward adoption? If so, why?

- Are the maternity homes providing a place, away from the subtle pressure in the community for a mother to keep her child, where women can make decisions which are appropriate for themselves?

- To what extent are maternity home residents encouraged to choose to place their babies for adoption and is this an appropriate decision?

- What are some of the factors that result in the variation among the homes in the proportion of residents keeping their babies?

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[55] Guyatt, loc. cit.

In addition to more information on the residents, it would be useful to have further data to help assess whether or not the objectives of the programs are being met. The following evalution questions could assess effectiveness.

- Is the health of maternity home residents and their infants better than that of an appropriate control group?
- Can maternity home counselling facilitate a resolution of emotional problems experienced by unwed pregnant women? Does it reduce the likelihood of a repeat pregnancy?
- Does a stay in a maternity home result in women making a more informed decision about whether or not to keep their babies as compared to women who do not enter a maternity home?
- Do those maternity home residents who keep their infants have more parenting skills, coping skills and confidence than those in an appropriate control group?
- Do the alternative educational experiences increase the likelihood that residents will obtain more education and a better work history than an appropriate control group?

Finally, it would also be helpful if evaluative research was undertaken to help clarify the appropriate role for maternity homes in the service system in the near future. The following questions could be explored.

- Can maternity homes help young pregnant unmarried women find or develop needed supports in the community in which they relocate?
- Do aftercare programs - namely, mother and baby programs - significantly decrease the risk for mothers and infants beyond what a stay in a maternity home up until the delivery might do?

In summary, there is value in doing further research in order to better understand the maternity home residents, to evaluate individual program objectives and to help clarify the role of the maternity homes. This research ought to be longitudinal or prospective, comparative and in depth. Such information would provide a data base from which to make sound program and policy decisions for maternity homes in the context of the larger service system.

### 6. Summary of Key Issues:

- the role of maternity homes in serving pregnant women and unmarried mothers;
- the extent to which applicants are aware of the programs of maternity homes;
- the extent to which maternity homes are accessible to other pregnant single women who might need the service of a maternity home but who might not be aware of the programs provided by maternity homes;
- the extent to which maternity homes effectively serve the many different groups of residents;
- the extent to which maternity home directors plan and implement programs which effectively serve residents and meet Ministry and/or community expectations with fixed funds;
- the value of undertaking more comprehensive research from which to make sound program and policy decisions.

## VII CONCLUSIONS

The major purposes of this paper were to document the types of programs provided by maternity homes and to relate these to the longer term role of maternity homes; to determine if the unmarried pregnant women who use maternity home service are at risk for parenting problems; to assist the individual homes and the Ministry Area Offices in the development and review of annual program and financial plans; and to provide direction for the development of a policy regarding future services and funding of adults receiving service from a maternity home. The paper has provided a profile of maternity home residents, looking at demographic, social and medical and health related factors. The characteristics of the sample populations were compared, where possible, to a previously studied group of maternity home residents and to unwed pregnant women in the general population. The comparisons helped to identify trends on a number of dimensions; however, this information was insufficient to determine whether or not the concern about unwed pregnant adolescent women, particularly those who plan to keep their babies, is valid. The profile of the residents has also provided a preliminary step toward determining the extent to which they are vulnerable or at risk. This information has been useful in providing direction for the development of a policy regarding the future services and funding of adults receiving service from a maternity home.

In addition, the paper has described the programs and services offered by maternity homes. A number of issues relating to programming have been identified and the residents' comments for changes in programs have been noted. Both the issues and suggestions relate to the longer term role of maternity homes.

The paper does, as well, provide a focus for future action. Three major suggestions for future work have been highlighted. They are as follows:

- It would be useful to have further comprehensive research undertaken in order to better understand the residents, to more accurately assess whether or not the objectives of the programs are being met and to help clarify the role for maternity homes.

- There is a need for collaboration between the maternity homes and the Ministry at the local level to further explore and resolve some of the issues facing maternity homes and possibly impeding service delivery.

- There is a need for collaboration among maternity homes, the Ministry and other service providers to develop a coordinated spectrum of service for unmarried pregnant women and unmarried mothers. It became evident in reviewing maternity homes that they are part of a larger system of services and consequently, resolution of issues pertaining to maternity homes need to be dealt with more comprehensively in the context of other relevant services.

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## APPENDIX 1

### Table #1

### Age of Residents

| | 1979 (N=245) | | 1981 (N=141) | |
|---|---|---|---|---|
| Age | % | (#) | % | (#) |
| 12 | 0.4 | (1) | 0.0 | (0) |
| 13 | 0.4 | (1) | 2.8 | (4) |
| 14 | 2.9 | (7) | 1.4 | (2) |
| 15 | 10.2 | (25) | 10.6 | (15) |
| 16 | 19.2 | (47) | 23.4 | (33) |
| 17 | 20.0 | (49) | 21.3 | (30) |
| 18 | 19.6 | (48) | 14.2 | (20) |
| 19 | 6.9 | (17) | 6.4 | (9) |
| 20 | 6.5 | (16) | 7.1 | (10) |
| 21 | 5.3 | (13) | 2.8 | (4) |
| 22 | 2.0 | (5) | 2.1 | (3) |
| 23 | 2.4 | (6) | 1.4 | (2) |
| 24 | 0.8 | (2) | 1.4 | (2) |
| 25 | 0.0 | (0) | 2.1 | (3) |
| 26 | 1.2 | (3) | 0.7 | (1) |
| 27 | 0.0 | (0) | 0.0 | (0) |
| 28 | 0.4 | (1) | 0.7 | (1) |
| 29 | 0.4 | (1) | 0.0 | (0) |
| 30 | 0.4 | (1) | 0.7 | (1) |
| 31 | 0.0 | (0) | 0.7 | (1) |
| 32 | 0.4 | (1) | 0.0 | (0) |
| 33 | 0.0 | (0) | 0.0 | (0) |
| 34 | 0.4 | (1) | 0.0 | (0) |
| TOTAL | 100.0 | (245) | 100.0 | (141) |

### Table #2

### Age of Maternity Home Residents Compared to Their Living Arrangements (1979)

| | <16 (N=34) | | 16-18 (N=144) | | 19-20 (N=33) | | 21+ (N=34) | |
|---|---|---|---|---|---|---|---|---|
| | % | (#) | % | (#) | % | (#) | % | (#) |
| Living Alone | 0 | (0) | 3.5 | (5) | 6.1 | (2) | 11.8 | (4) |
| Living with Putative Father | 2.9 | (1) | 4.9 | (7) | 6.1 | (2) | 8.8 | (3) |
| Living with Parents | 70.1 | (24) | 61.8 | (89) | 51.5 | (17) | 29.4 | (10) |
| Living with Other Relatives | 5.9 | (2) | 5.6 | (8) | 0 | (0) | 23.5 | (2) |
| Friends | 0 | (0) | 8.3 | (12) | 0 | (0) | 11.8 | (4) |
| In another Maternity Home | 0 | (0) | 2.1 | (3) | 3.0 | (1) | 2.9 | (1) |
| Other | 14.7 | (5) | 8.3 | (12) | 21.2 | (7) | 17.6 | (6) |

## Table 3

### Age of Maternity Home Residents Compared to Their Prior and Intended Living Arrangements (1981)

| | 16 (N=21) | | 16-18 (N=83) | | 19-20 (N=19) | | 21+ (N=18) | |
|---|---|---|---|---|---|---|---|---|
| | % | (#) | % | (#) | % | (#) | % | (#) |
| Living Alone: | | | | | | | | |
| Prior to Admission | 0 | (0) | 1.2 | (1) | 26.3 | (5) | 11.1 | (2) |
| Following Discharge | 4.8 | (1) | 15.7 | (13) | 31.6 | (6) | 33.3 | (6) |
| Living with putative father: | | | | | | | | |
| Prior to Admission | 4.8 | (1) | 10.8 | (9) | 10.5 | (2) | 11.1 | (2) |
| Following Discharge | 9.5 | (2) | 7.2 | (6) | 5.3 | (1) | 5.5 | (1) |
| Living with Parents: | | | | | | | | |
| Prior to Admission | 66.6 | (14) | 65.1 | (54) | 47.4 | (9) | 33.3 | (6) |
| Following Discharge | 57.1 | (12) | 55.4 | (46) | 31.6 | (6) | 22.2 | (4) |
| Living with Other Relatives: | | | | | | | | |
| Prior to Admission | 0 | (0) | 8.4 | (7) | 5.3 | (1) | 11.1 | (2) |
| Following Discharge | 9.5 | (2) | 4.2 | (5) | 5.3 | (1) | 11.1 | (2) |
| Living with Friends: | | | | | | | | |
| Prior to Admission | 4.8 | (1) | 6.0 | (5) | 5.3 | (1) | 11.1 | (2) |
| Following Discharge | 0 | (0) | 2.4 | (2) | 5.3 | (1) | 0 | (0) |
| Living in Another Maternity Home: | | | | | | | | |
| Prior to Admission | 0 | (0) | 1.2 | (1) | 0 | (0) | 0 | (0) |
| Following Discharge | 4.8 | (1) | 0 | (0) | 10.5 | (2) | 0 | (0) |
| Other: | | | | | | | | |
| Prior to Admission | 22.8 | (4) | 7.2 | (6) | 5.3 | (1) | 22.2 | (4) |
| Following Discharge | 4.8 | (1) | 2.4 | (2) | 0 | (0) | 5.5 | (1) |

## APPENDIX 2

## RISK INDEX

| | | Score | |
|---|---|---|---|
| 1. | Risk Age | | |
| | • if someone was less than 16 years of age | 1 | |
| | | | 1 |
| 2. | Risk Education | | |
| | • if someone was less than 16 years of age and was not a student prior to admission into the home or, if someone was 16 years or older and had left school at less than 16 years of age | 1 | |
| | | | 1 |
| 3. | Risk Work | | |
| | • if someone was older than 18 years, was not a student prior to admission into the home and was not working immediately before her pregnancy or, if someone was older than 18 years, was not a student prior to admission into the home and had more than three jobs in the last year | 1 | |
| | • if someone was older than 18 years, had a full-time job(s) before her pregnancy and was earning less than $200 a week | 1 | |
| | | | 2 |
| 4. | Risk Isolation | | |
| | • if someone had never received any visits and left the maternity home to visit family and friends once or twice a month, or, if someone had lived alone before entering the home and was intending to live alone following the birth | 1 | |
| | OR | | |
| | if someone had never received any visits, left the maternity home to visit family and friends once or twice a month, had lived alone before entering the home and was intending to live alone following the birth | 2 | |
| | • if someone's parents were unsupportive of her, or if someone's parents, boyfriend and friends were unsupportive of her | 2 | |
| | | | 4 |

### 5. Risk Agency Involvement

| | Score | |
|---|---|---|
| • if someone was referred to the home by probation and aftercare or another social service agency or, if someone had placed a previous child in temporary CAS care during her stay in the maternity home or, if someone had placed a previous child in the care of the CAS or, if someone had been a ward of the CAS or crown, or if someone had been a training school ward | 1 | |
| **OR** | | |
| if someone was referred to the home by probation and aftercare or another social service agency and had been a ward of either the CAS or the training school | 2 | |
| **OR** | | |
| if someone was referred to the home by probation and aftercare or another social service agency and had placed a previous child in temporary CAS care either during her stay in the maternity home or at some point prior to her admission | 2 | |
| **OR** | | |
| if someone was referred to the home by probation and aftercare or another social service agency and had placed a previous child in temporary CAS care either during her stay in the maternity home or at some point prior to her admission and had been a ward of either the CAS or the training school | 3 | |
| **OR** | | |
| if someone was referred to the home by probation and aftercare or another social service agency and had placed a previous child in temporary CAS care either during her stay in the maternity home and had placed a previous child in the care of the CAS at some point prior to her admission and had been a ward of either the CAS or the training school | 4 | |
| • if someone indicated that she had been using mental health or counselling services | 1 | 5 |

| | | Score | |
|---|---|---|---|
| 6. | Risk Health | | |
| • | if someone reported their health to be fair | 1 | |
| | **OR** | | |
| | if someone reported their health to be poor | 2 | |
| • | if someone saw a doctor for the first time in the fourth, fifth or sixth month of her pregnancy | 1 | |
| | **OR** | | |
| | if someone saw a doctor for the first time in the seventh, eighth or nineth month of her pregnancy | 2 | |
| | | | 4 |
| 7. | Risk Previous Pregnancy | | |
| • | if someone claimed that this pregnancy was not their first | 1 | |
| | | | 1 |
| | | Total | 18 |

**APPENDIX 3**

## TABLE 1
## ORGANIZATIONAL INFORMATION

| MATERNITY HOME | MANDATE | CHURCH AFFILIATION | STAFF | BOARD | VOLUNTEER PROGRAM |
|---|---|---|---|---|---|
| ARMAGH<br>(Mississauga) | - a group home for troubled adolescent women<br>- also serves pregnant women<br>- residential service only | Presbyterian Church | 16 staff | 24 members | No |
| BETHANY<br>(Toronto) | - serves pregnant women and mothers with their newborn babies<br>- a residential and non-residential service | Salvation Army | 14 staff:<br>8 full-time<br>6 part-time | N/A | Yes |
| BETHANY<br>(Ottawa) | - serves pregnant women only<br>- a residential and non-residential service | Salvation Army | 8 staff:<br>6 full-time<br>2 part-time | N/A | Yes |
| BETHEL<br>(Toronto) | - serves pregnant women and non-pregnant, disturbed adolescents<br>-a residential and non-residential service | Pentecostal Benevolent Association | 10 staff:<br>8 full-time<br>2 part-time<br>plus a student on placement | 15 members elected from the Board of Governors of the Pentecostal Benevolent Association | Yes |
| BETHESDA<br>(London) | - serves pregnant women only | Salvation Army | 9 staff:<br>5 full-time<br>4 part-time | N/A | No |
| FLORENCE BOOTH<br>(Thunder Bay) | - serves pregnant women (single or married) and mothers with their newborn babies | Salvation Army | 6 staff:<br>5 full-time<br>1 part-time | N/A | Yes |
| GRACE HAVEN<br>(Hamilton) | - serves pregnant women, new mothers and their infants and non-pregnant women, if space is available | Salvation Army | 12 staff:<br>7 full-time<br>5 part-time | N/A | Yes |
| HUMEWOOD<br>(Toronto) | - serves troubled adolescent girls in crisis, women in transition from psychiatric care and pregnant women<br>- a residential and non-residential service | Anglican Church | 14 staff:<br>13 full-time<br>1 part-time<br>+ 2 nursery workers for the pilot project;<br>7 contract staff | 25 members<br>half are members of the Anglican Church women | Yes |
| ROSALIE HALL<br>(Toronto) | - serves unmarried pregant women<br>- a residential and non-residential service | Catholic Church | 17 staff:<br>12 full-time<br>5 part-time | 15 members | Yes |
| ST. MARTIN'S MANOR<br>(Hamilton) | - serves pregnant women | Catholic Church | 6 staff: | 11 members: 10 of the members are appointed by the Board of Catholic Services | Yes |

## TABLE 2
## ADMISSION INFORMATION

| MATERNITY HOME | BED CAPACITY | OCCUPANCY (within year ending Feb/Mar 1981) | PER DIEM (As of Feb./Mar. 1981) | RESIDENT CONTRIBUTION (Suggested Amounts, Experience regarding Collection of Suggested Amounts | AGE ELIGIBILITY | EXCLUSION FACTORS | REFERRAL SOURCES |
|---|---|---|---|---|---|---|---|
| ARMAGH (Mississauga) | 12 (6 maternity residents) | Occupancy Rate: )<br>Waiting List: ) Stats. not available<br>Length of Stay: ) | $42.50 (group home and UM rate) | $10.00 per day | - 13-18 years | | Major Sources: Private referrals |
| BETHANY (Toronto) | 16 | Occupancy Rate: 93%<br>Waiting List: 8-10 people for 2-3 week period<br>Length of Stay: 4-5 months | $25.65 | $ 3.00 per day<br>- about 33% contribute | - 13-40 years<br>- majority between 15-19 years<br>- minority (20%) over 21 years | | Major Sources: hospitals, hostels, schools, public health nurses, self<br>Other: Salvation Army, CAS, Birthright, other maternity homes, probation and aftercare, clergy |
| BETHANY (Ottawa) | 12 | Occupancy Rate: 75%<br>Waiting List: Yes<br>Length of Stay: 3 months | $26.67 | $ 5.00 per day | - all ages<br>- average age 16 years<br>- about 5% over 21 years | | Major Sources: self (family), CAS<br>Other: doctors, psychiatrists, clergy, probation and aftercare, YWCA, Birthright, other maternity homes |
| BETHEL (Toronto) | 27 | Occupancy Rate: 99%<br>Waiting List: 3-4 people for about 3 weeks<br>Length of Stay: 2½ months | $24.91 | $10.00 per day<br>- about 30% contribute | - primarily 15-17 years<br>- few over 21 years | * girls with problems resulting from the use of alcohol or other types of drugs must be committed to attending an in-house program. | Major Sources: CAS<br>Other: guidance counsellors, Huntley Youth Services Birthright, Planned Parenthood, doctors, clergy, other maternity homes, self |
| BETHESDA (London) | 7 (to expand to 18) | Occupancy Rate: 100%<br>Waiting List: 5 people for 2-3 months<br>Length of Stay: 4 months | $33.00 | $ 5.00 per day<br>- about 40% contribute | - all ages<br>- majority between 14-16 years<br>- about 14%-28% over 21 years | | Major Sources: self<br>Other: parents, friends, doctors, nurses, schools, CAS, Birthright |
| FLORENCE BOOTH (Thunder Bay) | 10 | Occupancy Rate: 80%<br>Waiting List: Yes<br>Length of Stay: 4-5 months | $28.00 | $ 8.00 per day | - all ages<br>- majority between 15-17 years<br>- about 2% over 21 years | Religion/Ethnicity: all accepted<br>Physical/Mental Handicaps: Girls with handicaps are carefully assessed in terms of the type and severity and ability to cope with the program<br>Drug/Alcohol Problems: Girls with problems resulting from the use of drugs or alcohol are admitted, provided that their usage is discontinued while in the home<br>Catchment Area: Widespread | Major Sources: CAS, doctors, corrections, schools, clinics, self (family) |
| GRACE HAVEN (Hamilton) | 20 | Occupancy Rate: 100%<br>Waiting List: 4 people for 1 month<br>Length of Stay: 3 months | $19.00 | $3.00-$4.00 per day | - all ages<br>- majority between 16-20 years with an average age between 16-17 years<br>- few over 21 years | | Major Sources: CAS/CCAS<br>Other: Self (family), public health nurses, doctors, schools, hospitals, Birthright, Planned Parenthood, Charleton Hall Group Home, probation and aftercare, other maternity homes |
| HUMEWOOD HOUSE (Toronto) | 18 (4-5 maternity residents) | Occupancy Rate: 90%<br>Waiting List: Yes, for 2-3 week period<br>Length of Stay: 5 months | $41.71 | $ 8.00 per day<br>- few contribute<br>- residents who are employed are expected to contribute 20% of net salary | - 14-21 years<br>- average age 17-18 years<br>- few over 21 years | | Major Sources: CAS<br>Other: social service agencies, doctors, clergy, self, other maternity homes |
| ROSALIE HALL (Toronto) | 28 | Occupancy Rate: 88%<br>Waiting List: 3-4 names<br>Length of Stay: less than 6 months | $27.80 | $1.00-$5.00 per day<br>- about 35% contribute | - all ages<br>- average age 16-18 years<br>- about 15% over 21 years | | Major Sources: self, CAS, Birthright, schools, private organizations<br>Other: other maternity homes |
| ST. MARTIN'S MANOR (Hamilton) | 12 | Occupancy Rate: 100%<br>Waiting List: 4-5 names for 1-10 weeks<br>Length of Stay: 3-4½ months | $11.50 | $7.00-$11.50 per day<br>- about 20% of residents' parents pay full per diem<br>- Welfare pays $7.00 per day for recipients; payments go directly to Catholic Social Services | - 11-29 years<br>- average age 16-18 years | | Major Sources: CAS, Birthright, Parish<br>Other: self, other agencies, guidance counsellors, doctors, relatives |
| ST. MARY'S (Ottawa) | 28 | Occupancy Rate: 46%-60%<br>Waiting List: No | $19.72 | $5.00 per day | - all ages | | Major Sources: schools, CAS, Birthright |

TABLE 3
MATERNITY HOME PROGRAMS

| MATERNITY HOME | MEDICAL/HEALTH | LIFE SKILLS | COUNSELLING | PARENTING | AFTERCARE | EDUCATION |
|---|---|---|---|---|---|---|
| ARMAGH (Mississauga) | Pre-natal: No (women receive instruction from doctor or public health nurse on an individual basis)<br>Exercise: No<br>Examinations: Yes, by public health nurse weekly and by doctor regularly | Life Skills is part of the education program | Individual: Yes, by primary in-house worker, by a CAS worker, depending on plans for the baby and by the part-time chaplain (optional).<br>Group: Yes | No | No | Provided by: Local Board, 2 teachers<br>Number of Days: 5 days per week<br>Compulsory: Yes, with the exception of those working, actively searching for work or involved in an individual school program<br>Availability: Residents only |
| BETHANY (Toronto) | Pre-natal: Yes, by public health nurse weekly<br>Exercises: Yes, by the housemother<br>Examinations: Yes, by doctors, (at Wellesley Clinic or their own) regularly | Household duties: yes, compulsory<br>Recreation: yes<br>Other:<br>- a compulsory, bi-weekly crafts program<br>- job training program<br>- bi-weekly discussions with community people | Individual: Yes<br>Group: No | Yes, part of Mother and Baby Program | Yes: A Mother and Baby Program<br>Admission: Restricted to a few former residents 16 years of age and older<br>Length of Stay: 2 months | Provided by: Local Board, 1 teacher<br>Number of Days: 3 days per week (to be expanded to a 5 day program, Sept. '81)<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents & non-residents |
| BETHANY (Ottawa) | Pre-natal: Yes, by public health nurse and 2 local doctors weekly<br>Exercises: Yes, 5 days a week<br>Examinations: Yes, regularly by one or two local doctors or residents' own family physician | Household duties: yes, on a rotating basis<br>- also may assist with meal preparation<br>Recreation: Yes<br>Other: Sessions on budgeting, shopping and job skills | Individual: Yes, by a CAS worker and director<br>Group: Yes, by a CAS worker | Yes, for residents planning to keep their babies, or have already given birth. Available to non-residents as well. Run by a Family Life Educator from the YWCA | Yes: Post-natal care for mother only<br>Admission: Restricted to former residents<br>Length of Stay: a couple of weeks | Provided by: Local Board<br>Number of Days: 4 days per week (individual tutoring)<br>Compulsory: No<br>Availability: Residents & non-residents |
| BETHEL (Toronto) | Pre-natal: Yes, by staff nurse, weekly<br>Exercises: Yes<br>Examinations: Yes, by a doctor | Household duties: yes, compulsory on a rotating basis<br>Recreation: Yes, participation in 3 out of 4 activities is compulsory<br>Other: Job skill program taught by staff and manpower counsellors<br>- special program for pregnant women | Individual: Yes, by the youth worker or the in-house social worker and in some cases by a CAS worker as well<br>Group: No | Yes - an eight week early child care education course to begin fall 1981 in cooperation with the Board of Education | Yes: Post-natal care for mother only<br>Admission: Restricted to women who are relinquishing their babies for adoption and want to continue their schooling. Available to former and non-residents<br>Length of Stay: 6 weeks | Provided by: Local Board<br>Number of Days: N/A - individual tutoring<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents & non-residents |
| BETHESDA (London) | Pre-natal: Yes, an 8-week program<br>Exercises: Yes<br>Examinations: Yes, by a clinic (the home will have a doctor on staff as of Sept. '81) | Household duties: Yes, compulsory<br>Other: residents can assist with the shopping | Individual: Yes, by the director and a CAS worker<br>Group: No | No | No, to be implemented as part of expansion program | Provided by: Local Board<br>Number of Days: N/A - individual tutoring (A 5 day program has been approved)<br>Compulsory: No<br>Availability: Residents only |
| FLORENCE BOOTH (Thunder Bay) | Pre-natal: Yes, by a volunteer weekly<br>Exercises: Yes, daily<br>Examinations: Yes, by in-house doctor or own doctor regularly | Household duties: Yes, compulsory - also may assist with the cooking<br>Recreation: Yes<br>Other: job readiness program<br>- group sessions on improving interpersonal skills | Individual: Yes, by a CAS worker<br>Group: See Life Skills | Yes | Yes: A Mother and Baby program<br>Admission: Available to former & non-residents<br>Length of Stay: 3 months | Provided by: Local Board<br>Number of Days: 5 mornings per week<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents and non-residents |
| GRACE HAVEN (Hamilton) | Pre-natal: Yes, by a public health nurse weekly<br>Exercises: Yes<br>Examinations: Yes, regularly by a doctor | Household duties: Yes, compulsory (includes cooking)<br>Other: Mother/child nutrition<br>- 3 week series on money management, job search techniques, use of leisure time<br>- 8 week parenting program | Individual: Yes, by the in-house social worker or director<br>Group: Yes, by the in-house worker | Yes, on an "as needed" basis | Yes: A Mother and Baby program<br>Admission: Restricted to four mothers and their infants<br>Length of Stay: 3 months or until parenting skills are learned | Provided by: Local Board, 1 teacher<br>Number of Days: 5 mornings per week<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents & non-residents |
| HUMEWOOD HOUSE (Toronto) | Pre-natal: Yes, by the Family Planning Clinic - can participate weekly in "Preggy Group" | Household duties: Yes, compulsory - also may assist with meal preparations on weekends | Individual: Yes, by direct service staff and in some cases by workers from Huntley Youth Services, Family Services of a children's aid society | Yes, pilot project including a credit course on child development, management, nutrition and infant stimu- | Yes: Post-Natal Care for mother only<br>Admission: restricted to former residents whose babies are released for adoption or placed in CAS care. | Provided by: Special contract<br>Number of Days: 5 days/week<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents & non-residents |

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| BETHESDA (London) | - serves pregnant women only | Salvation Army | 9 staff:<br>5 full-time<br>4 part-time | N/A | No |
| FLORENCE BOOTH (Thunder Bay) | - serves pregnant women (single or married) and mothers with their newborn babies | Salvation Army | 6 staff:<br>5 full-time<br>1 part-time | N/A | Yes |
| GRACE HAVEN (Hamilton) | - serves pregnant women, new mothers and their infants and non-pregnant women, if space is available | Salvation Army | 12 staff:<br>7 full-time<br>5 part-time | N/A | Yes |
| HUMEWOOD (Toronto) | - serves troubled adolescent girls in crisis, women in transition from psychiatric care and pregnant women<br>- a residential and non-residential service | Anglican Church | 14 staff:<br>13 full-time<br>1 part-time<br>+ 2 nursery workers for the pilot project;<br>7 contract staff | 25 members half are members of the Anglican Church women | Yes |
| ROSALIE HALL (Toronto) | - serves unmarried pregant women<br>- a residential and non-residential service | Catholic Church | 17 staff:<br>12 full-time<br>5 part-time | 15 members | Yes |
| ST. MARTIN'S MANOR (Hamilton) | - serves pregnant women | Catholic Church | 6 staff: | 11 members: 10 of the members are appointed by the Board of Catholic Services | Yes |
| ST. MARY'S (Ottawa) | - serves pregnant women (single or married) | Good Shepherd Nuns of the Catholic Archdiocese | 8 staff:<br>7 full-time<br>1 part-time | 15 members | Yes |
| ST. MONICA HOUSE (Waterloo) | - serves pregnant women<br>- a residential and non-residential service | Anglican Church | 12 staff:<br>8 full-time<br>4 part-time<br>+ a student on placement | 22 members | Yes |
| VICTOR (Toronto) | - serves pregnant women and mothers with their infants<br>- a residential and non-residential service | United Church | 13 staff:<br>6 full-time<br>7 part-time<br>+ 5 seconded staff:<br>2 full-time<br>3 part-time | 14 members appointed by the United Church Council | Yes |

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| BETHESDA<br>(London) | 7<br>(to expand to 18) | Occupancy Rate: 100%<br>Waiting List: 5 people for 2-3 months<br>Length of Stay: 4 months | $33.00 | $ 5.00 per day<br>- about 40% contribute | - all ages<br>- majority between 14-16 years<br>- about 14%-28% over 21 years | | Major Sources: self<br>Other: parents, friends, doctors, nurses, schools, CAS, Birthright |
| FLORENCE BOOTH<br>(Thunder Bay) | 10 | Occupancy Rate: 80%<br>Waiting List: Yes<br>Length of Stay: 4-5 months | $28.00 | $ 8.00 per day | - all ages<br>- majority between 15-17 years<br>- about 2% over 21 years | Religion/Ethnicity: all accepted<br>Physical/Mental Handicaps: Girls with handicaps are carefully assessed in terms of the type and severity and ability to cope with the program<br>Drug/Alcohol Problems: Girls with problems resulting from the use of drugs or alcohol are admitted, provided that their usage is discontinued while in the home<br>Catchment Area: Widespread | Major Sources: CAS, doctors, corrections, schools, clinics, self (family) |
| GRACE HAVEN<br>(Hamilton) | 20 | Occupancy Rate: 100%<br>Waiting List: 4 people for 1 month<br>Length of Stay: 3 months | $19.00 | $3.00-$4.00 per day | - all ages<br>- majority between 16-20 years with an average age between 16-17 years<br>- few over 21 years | | Major Sources: CAS/CCAS<br>Other: Self (family), public health nurses, doctors, schools, hospitals, Birthright, Planned Parenthood, Charleton Hall Group Home, probation and aftercare, other maternity homes |
| HUMEWOOD HOUSE<br>(Toronto) | 18<br>(4-5 maternity residents) | Occupancy Rate: 90%<br>Waiting List: Yes, for 2-3 week period<br>Length of Stay: 5 months | $41.71 | $ 8.00 per day<br>- few contribute<br>- residents who are employed are expected to contribute 20% of net salary | - 14-21 years<br>- average age 17-18 years<br>- few over 21 years | | Major Sources: CAS<br>Other: social service agencies, doctors, clergy, self, other maternity homes |
| ROSALIE HALL<br>(Toronto) | 28 | Occupancy Rate: 88%<br>Waiting List: 3-4 names<br>Length of Stay: less than 6 months | $27.80 | $1.00-$5.00 per day<br>- about 35% contribute | - all ages<br>- average age 16-18 years<br>- about 15% over 21 years | | Major Sources: self, CAS, Birthright, schools, private organizations<br>Other: other maternity homes |
| ST. MARTIN'S MANOR<br>(Hamilton) | 12 | Occupancy Rate: 100%<br>Waiting List: 4-5 names for 1-10 weeks<br>Length of Stay: 3-4½ months | $11.50 | $7.00-$11.50 per day<br>- about 20% of residents' parents pay full per diem<br>- Welfare pays $7.00 per day for recipients; payments go directly to Catholic Social Services | - 11-29 years<br>- average age 16-18 years | | Major Sources: CAS, Birthright, Parish<br>Other: self, other agencies, guidance counsellors, doctors, relatives |
| ST. MARY'S<br>(Ottawa) | 28 | Occupancy Rate: 46%-60%<br>Waiting List: No<br>Length of Stay: 5-6 months | $19.72 | $5.00 per day | - all ages<br>- average age is 17 years<br>- a number are over 21 years | | Major Sources: schools, CAS, Birthright<br>Other: parents, priests, doctors |
| ST. MONICA HOUSE<br>(Waterloo) | 18 | Occupancy Rate: 100%<br>Waiting List: 5-10 names for 2-8 weeks<br>Length of Stay: 3-4 months | $28.00 | $4.00-$5.00 per day<br>about 25% contribute | - all ages<br>- majority between 14-18 years with an average age 15-17 years<br>- 5%-10% are over 21 years | * girls with an alcohol or drug problem are ineligible for admission | Major Sources: CAS, self<br>Other: families, schools, hospitals, doctors, public health nurses, clergy, friends, Birthright, Right to Life, Planned Parenthood, other maternity homes |
| VICTOR<br>(Toronto) | 22 | Occupancy Rate: Close to 100%<br>Waiting List: Yes, for a period of 2-4 weeks | $28.00 | $7.00-$10.00 per day | - up to 30 years<br>- average age 17 years<br>- about 18% over 21 years | * psychotics are ineligible for admission<br>* girls with alcohol or drug related problems must be willing to work out their problem | Major Sources: CAS, self, public health nurse<br>Other: Birthright, Right to Life, information centres, youth counselling agencies, corrections, institutions for mentally retarded, mental health centres, hospitals, clergy, other maternity homes |

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| | Examinations: Yes, regularly by a doctor | - 3 week series on money management, job search techniques, use of leisure time<br>- 8 week parenting program | | | | |
| **HUMEWOOD HOUSE** (Toronto) | Pre-natal: Yes, by the Family Planning Clinic - can participate weekly in "Preggy Group"<br>Exercises: Yes, in "Preggy Group"<br>Examinations: Yes, regularly by a doctor | Household duties: Yes, compulsory - also may assist with meal preparations on weekends<br>Other: weekly program on accommodation, budgeting & cleaning by child care staff & community persons | Individual: Yes, by direct service staff and in some cases by workers from Huntley Youth Services, Family Services of a children's aid society<br>Group: No | Yes, pilot project including a credit course on child development, management, nutrition and infant stimulation as well as a practicuum in the home's nursery<br>- compulsory for all pregnant residents<br>- available to non-residents | Yes: Post-Natal Care for mother only<br>Admission: restricted to former residents whose babies are released for adoption or placed in CAS care.<br>Length of Stay: a couple of months | Provided by: Special contract<br>Number of Days: 5 days/week<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents & non-residents |
| **ROSALIE HALL** (Toronto) | Pre-natal: Yes, by the St. Elizabeth Visiting Nurses for 8 weeks<br>Exercises: Yes<br>Examinations: Yes, by a doctor weekly or by a public health nurse twice a week | Household duties: Yes, including meal preparation on the weekends<br>Recreation: Yes, some compulsory<br>Other: Sessions on self-improvement skills & job searching by a teacher and community persons;<br>- weekly group sessions on plans for the baby | Individual: Yes, by the in-house social worker and a CAS/CCAS worker<br>Group: See Life Skills | Yes, part of pre-natal program.<br>- women intending to keep their babies are encouraged to do babysitting for the CAS | No | Provided by: Local Board<br>Number of Days: N/A - individual tutoring<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents & non-residents |
| **ST. MARTIN'S MANOR** (Hamilton) | Pre-natal: Yes, by St. Elizabeth Visiting Nurses and by a volunteer staff daily<br>Exercises: Yes<br>Examinations: Yes, by a doctor weekly or bi-weekly | Household duties: Yes, compulsory, on a rotating basis<br>Recreation: Yes<br>Other: Life Skills taught by house-mothers;<br>- a 12-week family life program in cooperation with parents from the community | Individual: Yes, by the director and a CAS worker and chaplain (optional)<br>Group: Yes, by home staff and CAS worker<br>Other: Counselling sessions with the family & boyfriend where possible | Yes, part of family life program.<br>The home operates a parent modelling program with CCAS, in which the baby is placed temporarily in foster care and the mother is taught coping skills by the foster parents. | Yes: Post-natal Care for mother only<br>Admission: restricted to former residents for the purpose of recuperation or resolving feelings of separation and mourning.<br>Length of Stay: 7-10 days | Provided by: Local Board, 6-8 teachers<br>Number of Days: 5 days/week, although individual tutoring.<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents only |
| **ST. MARY'S** (Ottawa) | Pre-natal: Yes, by a registered nursing assistant weekly<br>Exercises: Yes, daily<br>Examinations: Yes, by a doctor | Household duties: Yes, compulsory, including cooking<br>Other: Sessions on assertiveness training and self-growth | Individual: Yes, by the in-house worker and guidance counsellors<br>Group: Yes, by the in-house worker and guidance counsellors | No | Yes: Post-natal Care for mother only<br>Admission: Restricted to former residents<br>Length of Stay: 90 days (maximum) 4 weeks (average) | Provided by: Local Board<br>Number of Days: N/A - individual tutoring<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents only |
| **ST. MONICA HOSUE** (Waterloo) | Pre-natal: Yes, 2 weekly programs by public health nurse and by the Kitchener-Waterloo Hospital<br>Exercises: Yes<br>Examinations: Yes | Household duties: Yes, compulsory, including cooking<br>Other: program including a manpower series, skills for decision-making and informative sessions on drugs, legal issues, interpersonal relationships. Available to non-residents | Individual: Yes, by the in-house worker and a CAS worker<br>- Available to non-residents<br>Group: Yes (i.e. house meetings) | Yes, taught by a variety of community professionals.<br>Available to non-residents and putative father. | Yes: Post-natal care for mother only<br>Admission: Restricted to former residents for the purpose of completing a school term or arranging housing<br>Length of Stay: Short period of time | Provided by: Local Board, 1½ teachers<br>Number of Days: 5 mornings/week<br>Compulsory: Yes, for residents less than 16 years<br>Availability: Residents & non-residents |
| **VICTOR** (Toronto) | Pre-natal: Yes, by the public health nurse<br>Exercises: Yes, by the public health nurse<br>Examinations: Yes, by the clinic at Women's College Hospital | Household duties: Yes<br>Recreation: Yes<br>Other: crafts program<br>- living skills (part of school curriculum<br>- COTA worker assists the residents with budgeting, shopping and meals | Individual: Yes, by the in-house worker and a CAS worker<br>Other: Sessons with family and boy friend, where possible | Yes, by tne public health nurse, houseparents, and a volunteer | Yes: A Mother and Baby program<br>Admission: Restricted to four former residents or non-former residents.<br>Length of Stay: 2 months | Provided by: Local Board, 3 part-time teachers<br>Number of Days: 5 half days/week<br>Compulsory: Yes, except those taking a job training course or those with serious handicaps.<br>Availability: Residents & non-residents |

POOR

QUALITY

ORIGINAL